The Modern Hospital

FEBRUARY 1956

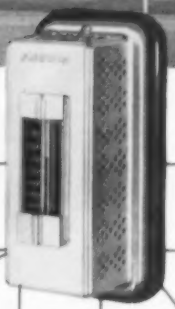
HOSPITAL NURSES RIDE FIREBOAT IN CHICAGO FIRE SAFETY DEMONSTRATION (page 70)

SMALL HOSPITAL INSURES

Ideal Temperatures

Waste-Free Heating and Cooling

with JOHNSON CONTROL



The new 45-bed St. Joseph Hospital* in Del Norte, Colorado, is an excellent example of the modern approach to the problem of temperature and humidity regulation in the smaller hospitals. The correct solution to that problem is a system of Johnson *Individual Room* Control engineered to meet the exact needs of the individual building.

AIR CONDITIONED AREAS

At St. Joseph's, in the air conditioned operating and delivery sections, optimum temperatures are maintained constantly by strategically located Johnson Thermostats in each individual room. The humidity of the conditioned air is also controlled at all times by Johnson Room Humidostats. Complete safety, *even in the presence of explosive anesthetic gases,* is assured by the use of pneumatic control apparatus.

HEAT REGULATION

During the heating season, Johnson *Individual Room* Thermostats control Johnson Valves on convectors to insure the exact temperature desired in all other rooms of the building, including all patient rooms, offices and public areas. Comfort control is also provided on the building's unit ventilators.

In addition to *individual room* control, behind the scenes other Johnson Thermostats, Valves, Dampers and other controllers regulate the basic operation of the heating and air conditioning equipment. All apparatus is combined into a single, highly efficient system that not only provides the finest in individual room temperature regulation but accomplishes all this at the lowest possible heating and cooling cost.

YOUR OWN HOSPITAL

Why don't you be sure of getting these same high standards of comfort, convenience and economy in your hospital, regardless of its size? Johnson has over 70 years' experience in solving the temperature regulation problem of all kinds of hospitals—*more specialized experience than anyone else!*

Whether you are planning a new building or modernizing part or all of an existing hospital, a nearby Johnson engineer will gladly give you his recommendations without obligation. To get all the facts on Johnson Control, call your nearest branch office or write Johnson Service Company, Milwaukee 1, Wisconsin. Direct Branch Offices in Principal Cities.

JOHNSON CONTROL

TEMPERATURE AIR CONDITIONING

PLANNING • MANUFACTURING • INSTALLING • SINCE 1885

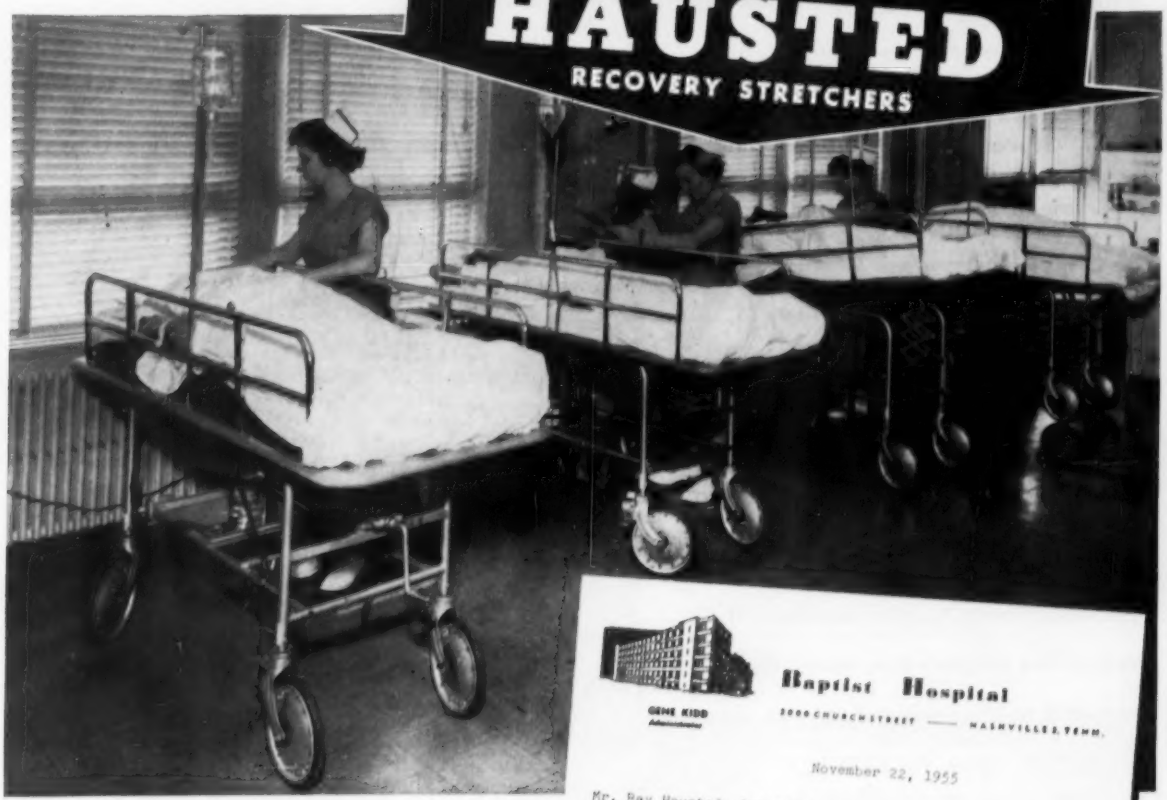
**St. Joseph Hospital, Del Norte, Colorado. Thomas & Sweet, architects, Colorado Springs; K. J. Murray, mechanical engineer, Denver, Howard Whitlock Construction Co., general contractor, Pueblo; Brickham & Tomberlin, mechanical contractor, Denver.*

Baptist Hospital Recovery Room Increases Efficiency of Patient Care

WITH

HAUSTED

RECOVERY STRETCHERS



GENE KIDD
Administrator

Baptist Hospital

2000 CHURCH STREET — NASHVILLE 3, TENN.

November 22, 1955

Mr. Ray Hausted, President
Hausted Manufacturing Company
Medina, Ohio

Dear Mr. Hausted:

I thought you might be interested in receiving a picture showing the ten Hausted wheel stretchers in our new Recovery Room.

I want to tell you how pleased we are with the versatility and efficiency of these units. I can conscientiously state that these stretchers have measured up to our expectations in every way and to date have not required any maintenance or service.

We felt at the time of consideration of equipment that the Hausted Stretcher was the best buy available. The many features of your equipment considering the price, appearance, maneuverability and durability as against competitive products was reason enough for us to purchase ten of these units. The Hausted stretchers have made it possible for fewer nurses to give better care to more patients. Our anesthesiologist and nursing personnel are very pleased with them in all respects.

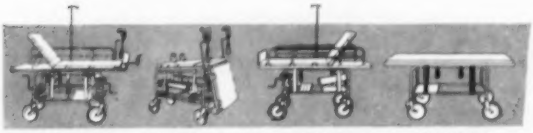
With very best wishes for your continued success, I remain

Sincerely yours,

Gene Kidd
Administrator

Mr. Kidd's kind words about Hausted equipment are not at all unusual. From hospitals all over the world we hear the same story . . . "finest equipment we ever owned" . . . "better patient care with fewer nurses" . . . "fewer transfers of patients" . . . "most versatile wheel stretchers we've ever seen" . . .

When you are considering new equipment for your recovery room, ask for a demonstration of Hausted stretchers, with today's most complete line of accessories.



EASY LIFT CONVER-TABLE STANDARD ECONOMY

HAUSTED MANUFACTURING COMPANY • MEDINA, OHIO

The Modern Hospital

FEBRUARY 1956

VOLUME 86, NO. 2

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Lilly

Therapeutic Briefs

SELECTED SEDATIVE-HYPNOTIC PRODUCTS

THE TOUCH OF SLEEP

VALMID

(Ethinamate, Lilly)

Nonbarbiturate sedative with a four-hour action span. The very short action means bright awakening without "hang-over," drowsiness, or depression. 'Valmid' also offers a wide margin of safety.

Supplied as Tablets 'Valmid,' 0.5 Gm. (7 1/2 grains) (scored), in bottles of 100 (1799).

WHEN SEDATION MUST BE QUICK YET SUSTAINED

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Combines in a single pulvule equal parts of quick-acting 'Seconal Sodium'* and moderately long-acting 'Amytal Sodium.'†

Supplied in three convenient dosages of 3/4, 1 1/2, and 3-grain pulvules.

*'Seconal Sodium' (Secobarbital Sodium, Lilly)
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FASTEST AND SHORTEST-ACTING BARBITURATE

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Supplied in pulvules, ampoules, suppositories, powder, and 'Enseals' (Timed Disintegrating Tablets, Lilly).

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AMYTAL SODIUM

(Amobarbital Sodium, Lilly)

Its usefulness extends into the fields of clinical medicine, surgery, anesthesiology, psychiatry, and many other specialties. A safe and predictable sedative-hypnotic.

Supplied in 1 and 3-grain pulvules; and ampoules of various strengths.

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AMONG THE AUTHORS


Harvey Machaver

Harvey Machaver, co-author of the "Flying Squad" article on nursing appearing on page 79 of this issue, is assistant director at Montefiore Hospital, New York, a position he has held for the last two years. Prior to accepting his present appointment in 1954, Mr. Machaver was personnel director at Jewish Hospital, Brooklyn, for four years. A graduate of the University of California, he took his master's degree in industrial and labor relations at Cornell University.


Dorothy A. Rehm

Dorothy A. Rehm, co-author with Mr. Machaver of the nursing article, is a graduate of the Mount Vernon Hospital School of Nursing, Mount Vernon, N.Y., with bachelor's and master's degrees in nursing from Teachers College, Columbia University. She is presently educational coordinator at the Montefiore Hospital, where she and Mr. Machaver have worked out the system described in their article in this issue.


Neil McGinniss

Neil McGinniss is administrative resident at the Oakwood Hospital, Dearborn, Mich., under the preceptorship of Jacques Cousin, hospital director. A graduate of the University of Cincinnati, Mr. McGinniss is working toward the master's degree in hospital administration from Columbia University. He will complete his year's residency this month, when he returns to Columbia to complete his work for graduation next June. Before going to Columbia, Mr. McGinniss was associated for five years with the Bethesda Hospital at Cincinnati, as assistant credit manager, purchasing agent and administrative assistant. His article on a linen control system appears on page 128 of this issue.


Dr. Cecil G. Sheps

Dr. Cecil G. Sheps, whose concept of the proper functions of the hospital in the community appears on page 90, has been executive director of Beth Israel Hospital, Boston, since September 1953. Prior to that time he was director of program planning and research professor of health planning in the division of health affairs at the University of North Carolina, where he also held an appointment in the Institute for Research in Social Science. He is presently lecturer on preventive medicine at Harvard University. A native of Winnipeg, Man., Dr. Sheps is a graduate of the University of Manitoba Medical College, with a degree in public health from Yale University. He is a diplomate of the American Board of Preventive Medicine. In 1951, Dr. Sheps was awarded a traveling fellowship by the World Health Organization to study medical problems in Western Europe. He is senior author of a book entitled "Needed in Health and Medical Care" published by the University of North Carolina Press and has been a frequent contributor to scientific and professional journals. Recently, Dr. Sheps was appointed special consultant to the research grants branch, Division of Hospital Facilities, U.S. Public Health Service.

READER OPINION

Hospitals and the GP

Sirs:

I read with interest the article on "Hospitals and the General Practitioner" by Dr. DeTar.

In the first place, it obviously and admittedly covers only one side of the question, and I would concur in all the comments which your editorial brings out with respect to this point.

In addition, I have never felt that hospitals were the prime instigators of the changes that have taken place in the last 30 years in the field of medicine and medical practice. Hospitals have been rather the place where some of these changes have taken place. For example, the rise of the specialist has not been a phenomenon dreamed up by certain hospital administrators or governing boards. It has happened because the natural trend in that direction was so strong that no one group could have stopped it even though it might have desired to do so.

There are no villains in the piece. But if there are any *controlling forces*, and I am not sure these trends can be controlled, they are the forces of medical education, and the agencies which establish standards for the approval of internships and residencies. You know how much the hospitals have to say about either of these two fields—nothing at all.

In most hospitals, medical matters are decided on the basis of the recommendation of a medical group. Only flagrant examples of malpractice, professional incompetence, or personal corruption are handled by the governing board, and even in these cases the board usually relies on a recommendation from the doctors on the staff.

As a practical matter, no board would dare insist on giving privileges to any individual doctors or class of doctors over the serious objections of the medical staff, because then it would be personally responsible for the quality of the medicine practiced by those individuals, and, if something went wrong, the staff would not only fail to back up the board but would be in a very good position to say "I told you so." All high minded phrases and principles to the contrary, it just isn't going to happen that way.

By the same token, I cannot conceive of a governing board that would not gladly admit general practitioners to its staff if the medical members of the staff would recommend it, or even merely agree to it. Most members of governing boards are highly sensitive to public reactions, and the public, by and large, has shown that it would support privileges for general practitioners.

So the *primary* responsibility lies squarely in the hands of the medical staff of a given hospital. If it is a "teaching hospital" closely affiliated with a medical school, its departmental heads are sensitive to the trends and pressures of medical education. If it is not a teaching hospital, the only significant forces that can be brought to bear come from the American Medical Association and the specialty boards. The influence of the hospital administrator and the governing board of the hospital is almost negligible if

it happens to be out of line with those other forces.

There is another factor which I have never seen mentioned before that can be almost controlling regardless of anything I have brought out here. This factor relates to the *occupancy* in a given hospital, and the pressure for beds. When a hospital is running at full capacity all or most of the time, a general practitioner has no chance of getting on the staff of that hospital. Neither has the average specialist, for that matter. Such a hospital may occasionally admit to its staff a specialist in a certain field which has not previously been represented, or where the existing specialists can admittedly not handle the patient load and themselves ask for additional help, but no one else has a chance. Again there are no villains, and the only solution is for the hospital to add more beds. This is not always possible or desirable, however, and this is particularly true when the hospital reaches a given size, which taxes all its service departments to the full extent.

Another factor of great importance —controlling importance here in our hospital in Albany, for example—is the war situation, either hot as it was in the Forties or cold as it now is. In the early and middle Forties we developed a three-year residency in general practice of which any hospital could be proud. It had the support of the staff and the department heads. It failed because just about that time the ruling came down from the armed forces that no one could spend more than nine months (now 12 months) in intern or residency training (except under special circumstances which did not apply here). This ruling dried up our source of applicants almost overnight, and eventually forced us to discontinue offering this residency. Otherwise, I feel sure it would have been successful, and might have been widely copied throughout the country.

The same fate met our two-year internship, which was also an excellent foundation for general practitioners.

So you can see why I say that it is not the hospitals' fault that the present situation exists, nor can the hospitals do much about it that I can see. I am personally in favor of training large numbers of general practitioners and training them well. I do not subscribe to the idea that we are heading toward the specialty practice of medicine exclusively. Yet there is nothing that I can see to do to stem the trend. Our hospital has general practitioners on its staff and they have no complaints that I know of. But we can't add more because we do not have enough beds to meet our present demands. We run full all year in general medicine and surgery, and during the five winter months from January through May the waiting lists are long and the pressure for beds is tremendous.

In conclusion, may I repeat that if there are any changes to be made in the present situation, the only groups capable of making them are the Association of American Medical Colleges and the deans of the medical schools, the specialty boards, the accrediting agencies, and the American Medical Association. It is a waste of time to try to hold hospitals responsible for the present situation or to expect them to be able to make any significant changes in current trends.

Thomas Hale Jr., M.D.
Director

Albany Hospital
Albany, N.Y.

(*Continued on Page* 10)

Economics of Food Service

Sirs:

The May report on the "Economics of Hospital Food Service" in the October issue of The MODERN HOSPITAL is an excellent survey, well organized and carried out to the last detail. It represents a tremendous amount of work and can be of great help to the administrator and dietitian. The dietitian knows many of the factors discussed but may have difficulty in getting the cooperation of the administrator or trustee. This report will help to give weight to her arguments. It should be a "must" on every trustee's and administrator's reading list. If the dietitian who is planning a new kitchen or remodeling an old one has an authority such as this to back up her requests, she is much more likely to get what is needed to run an efficient dietary department.

The survey states it is easy for a trustee, administrator or layman to understand food service. Is it? Everyone feels he knows all about food and its service. There is the constant tendency to compare hospital food service with that of hotels and restaurants and they just can't be compared because: (1) Hotels, unlike hospitals, give a limited amount of room service. (2) Hotel service is carried from a preparation area directly to the customer—not on a tray or a moving belt or carted through corridors into elevator to floor pantry to patient. (3) Hotels do not have to serve 300 or more meals at one time three times a day; they serve over a longer period.

The research leading up to the conclusion that central tray service is most satisfactory, like all other areas surveyed, is infinite in its detail. The yardstick "time elapsed" is good but the conclusion is not necessarily true. Distance is in direct proportion to time elapsed. Add to this the fact that when the tray arrives at the bedside the patient, for any one of many reasons, may not be ready for the tray or may not even want to eat. What does the dietitian do then—take it back to the kitchen at some distance to keep it hot or discard? One can have an ideal physical setup but there is still the human element to contend with as far as serving a tray is concerned. Perfect physical layout and reasonable man-hours do not in any way ensure patient satisfaction, which, after all, is what we are striving for.

On the whole, however, this survey is an excellent yardstick for the dietitian to use in evaluating her department as to work areas, man-hours, and food service to both patient and personnel.

Effie M. Winger
Chief Dietitian
New England Deaconess Hospital
Boston

Sirs:

The May report is the first paper of its kind and I have been very much interested in the method of survey and of obtaining information. I tried using it on different phases of our work, such as man-hours per thousand meals and thermal efficiency of our equipment, and we found that our operation ties in fairly closely with that of the small hospital. I also kept Mr. May's report closely in mind when doing a survey on a small hospital and found it very beneficial.

E. Alliene Mosso
Director of Dietetics
St. Luke's Hospital
New York City

Kidnaping Story Helpful

Sirs:

I am exceedingly grateful to The MODERN HOSPITAL for publishing the details of the Mount Sinai, San Francisco, baby kidnaping from the nursery there. The way in which these details were presented is of tremendous importance to all of us right now, particularly in our case at a time when we were just designing an emergency door out of our nursery. We got several good ideas from the detail drawing accompanying this article as well as the facts given in this very dramatic story.

A. Neal Deaver
Administrator
Independence Sanitarium and Hospital
Independence, Mo.

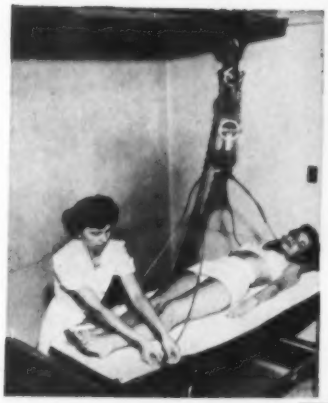
Paper Food Service

Sirs:

I was much interested in the article by Arnold S. Lane (December 1955) on paper food service. Are the paper plates and cups entirely adequate for hot meals, that is, do they curl up at all or dissipate the heat too quickly? We would appreciate any further details you can give us.

H. F. Hancox
John C. Lincoln Hospital
Phoenix, Ariz.

Cleaned in a Few Minutes...READY FOR NEXT PATIENT



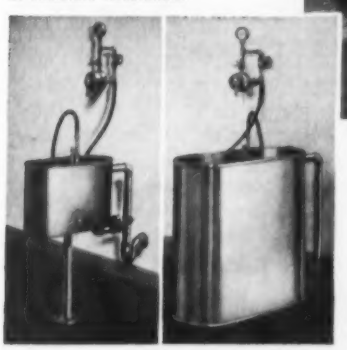
Blickman stainless steel equipment with seamless, round-corner construction, speeds service in Hydrotherapy Department

• This stainless steel underwater treatment tank can be thoroughly cleaned and made ready for the next patient in a matter of minutes. All surfaces are smooth and continuous. There are no seams, crevices or joints of any kind. The highly polished stainless steel reduces adhesion of dirt and grime. Cleaning takes far less time and effort, because all corners and intersections are fully rounded. Complete asepsis is attained with a minimum of labor. This means that you save money every day you use this long-lasting unit. That's why so many leading hospitals have standardized upon Blickman-Built hydrotherapy and physiotherapy equipment in sanitary stainless steel. We invite you, too, to *investigate and compare*, before you buy.

ABBOTT Model I-Beam Hoist of all stainless steel remains free of rust and corrosion, no matter how much hot, moist steam arises from the hydrotherapy tank.

HOT SPRINGS Model Underwater Treatment Tank—as used in St. Mary's Hospital, E. St. Louis, Ill. Designed for ready access to all parts of patient's body. After each treatment, tank is drained, scrubbed and brushed with surgical soap. Cleaning is easy because of the polished stainless steel surfaces and the round-corner construction. Aerators circulate water through pressure action, not by electrical means. Danger of shock is eliminated.

Below, left to right: HARVEY Model Stainless Steel Arm Bath permits patients to tolerate higher water temperatures as air is introduced to give swirling motion. RADCLIFFE Model stainless steel leg bath provides a whirlpool action proved efficacious in treating local areas to stimulate circulation.



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Send for Catalog 6-HYC describing and illustrating more than 40 different items of stainless steel equipment for Hydrotherapy and Physiotherapy Departments.

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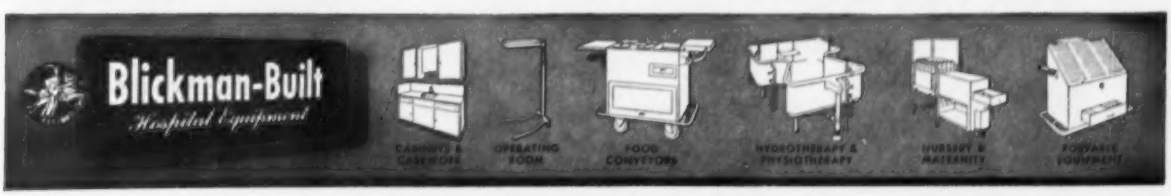
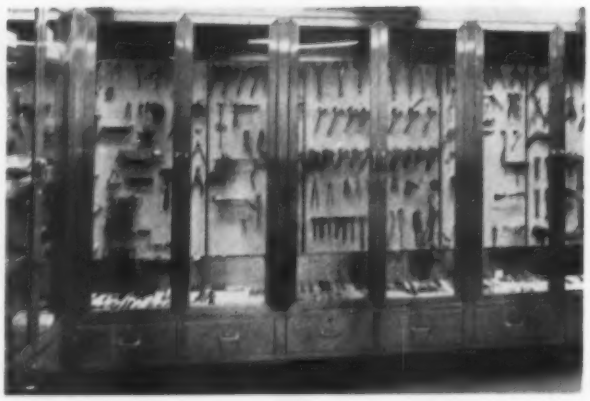


You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 26-28.

ROVING REPORTER

Instruments on Display

A unique instrument storage cabinet was installed recently at Children's Hospital in Los Angeles as part of an extensive improvement program. The back of the cabinet is made of perforated metal to which a variety of pegs and hooks can be attached in any desired arrangement. Operating room nurses report that the new case has many advantages over the conventional type, particularly when it comes to finding instruments quickly.



The tool displays in hardware stores gave Administrator Smits the idea for this instrument display cabinet at Children's Hospital, Los Angeles.

The cabinet is located in a recess off the operating room corridor, and is easily accessible from all rooms. It was designed by Anthony Thormin, architect, at the suggestion of J. E. Smits, administrator, who got the idea from hardware stores' tool displays.

Survey of Senility

If someone tells you that mental hospitals contain hundreds of aged persons who do not belong there, you can tell them that a Yale man can prove it isn't so.

Dr. Sidney Shindell, lecturer in medical jurisprudence at Yale University and medical director of the Connecticut State Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm, made a survey recently in his own state. Out of 10,289 patients in Connecticut's mental hospitals, only 1.5 per cent could reasonably be termed "seniles" who might be cared for in another type of institution, he found.

The Connecticut pyschiatric hospitals had 4178 patients 60 years old or older, but of these, 2675 had grown old in the hospital. Of the remaining 1503 elderly persons, 1012 showed antisocial behavior problems.

"No matter what kind of sugar coating you put on the pill, it still takes a group of people who know how to care for mental illness to care for many 'senile' patients," Dr. Shindell declared.

"It is important to dispel all fictions about the so-called problems of senility so that we can plan more effectively for the mentally ill on one hand and the disabilities accompanying physical illness or advanced age on the other without the waters being muddied by misconceptions," he asserted in commenting on the survey.

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Control as they open

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Dor-O-Matic's advanced design and construction produce a positive door closing action, longer service life under all conditions, and complete adaptability to contemporary design and function. In addition, Dor-O-Matic features a positive back-stop, built-in hold-open device (optional) and two-speed closing control. Choose from 25 models. There's one for every type door . . . in any type building.

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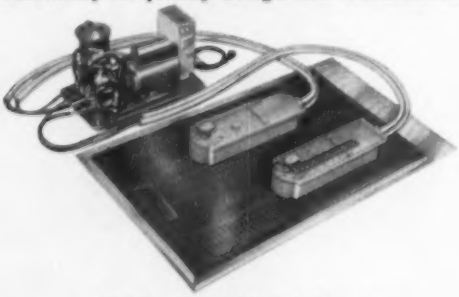
Completely Noiseless—The Invisible Dor-Man can be installed for perfectly silent service. Not a whisper is heard from it as the door glides open and closes . . . mute testimony to quality design and construction.



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Flooring Contractor: Sidney Fenster, Inc.

Widely acclaimed, New York's Upper Manhattan Medical Group Clinic integrates the highest standards of architecture, function and decor in an ideal union . . . in which MATICO Confetti tile is an essential specified element.

MATICO Confetti® tile flooring

Easily installed and easy to clean, even under heavy traffic conditions in circulation areas, Confetti helps keep costs down.

Saves on installation and maintenance

In this intimate waiting room, the decor is one of colorful furnishings, restful lighting and more of MATICO's bright, long-lasting Confetti tile.

Gives years of trouble-free wear

Architects planned the pharmacy as a "display piece" near the Clinic's entrance. Attractive Confetti in white with black mottle was used.

Looks brighter, stays cleaner longer

Is low-priced . . .
economical to maintain . . .
beautiful in appearance!

It's easy to see why more and more hospitals are using MATICO Confetti in asphalt or vinyl-asbestos tile flooring.

Basically, it's because Confetti satisfies every need, every rigid requirement of the modern hospital. First, it is sanitary, durable and quietly resilient. But more than that, *it is low in cost for both installation and maintenance.* And, in addition to all these utility values, Confetti's gay dots-of-color styling lends new charm and cheer where past custom dictated hygienic coldness.

Good reasons, all, why Confetti tile flooring is selected for so many modern hospitals across the country.

QUALITY CONTROLLED MATICO PRODUCTS Guaranteed by Good Housekeeping

MASTIC TILE CORPORATION OF AMERICA

Houston, Tex. • Joliet, Ill. • Long Beach, Calif. Newburgh, N. Y.

Confetti • Aristoflex • Parquetry • Maticork • Asphalt Tile Rubber Tile • Vinyl Tile • Cork Tile • Plastic Wall Tile

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OF GROWING IMPORTANCE

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ELECTRONIC PRODUCTS

of outstanding quality and efficiency – now – and in the future

RAYTHEON MANUFACTURING COMPANY

Equipment Marketing Department – Medical Sales, Waltham 54, Massachusetts

EXCELLENCE IN ELECTRONICS

are all your patients properly identified?

The Hollister Ident-A-Band® System provides your hospital with low-cost insurance against damaging patient mix-ups. Why is this so important? Because of what *has* happened and what *can* happen when patients are not properly identified:

- wrong patient having operation intended for someone else
- patient transfused with the wrong blood type because of mistaken identity
- powerful drug administered to the wrong patient
- wrong patient given a laboratory test, resulting in critical delay of treatment for the right patient
- wrong patient X-rayed, resulting in wrong diagnosis of the right patient's illness
- wrong patient given radium treatment – resulting in irreparable damage
- critical time wasted because staff was not sure of unconscious patient's identity
- staff not able to identify a confused patient who was taken from one hospital building to another
- critical time wasted because staff did not know the patient's blood type
- wrong baby given to a maternity patient because of name similarity, resulting in a baby mix-up

Mistakes like these often result in costly law suits, loss of community goodwill and sometimes there may be tragic consequences. This serious situation can be averted by identifying all your patients. Ident-A-Band provides your staff with *complete* information . . . it shows the patient's full name, his hospital chart number, his doctor's name, his blood type, or what other vital data is required.

Each Ident-A-Band is securely sealed on the wrist, and will stay on until the patient is discharged.

To learn more about this protective identification, send in the attached coupon now.

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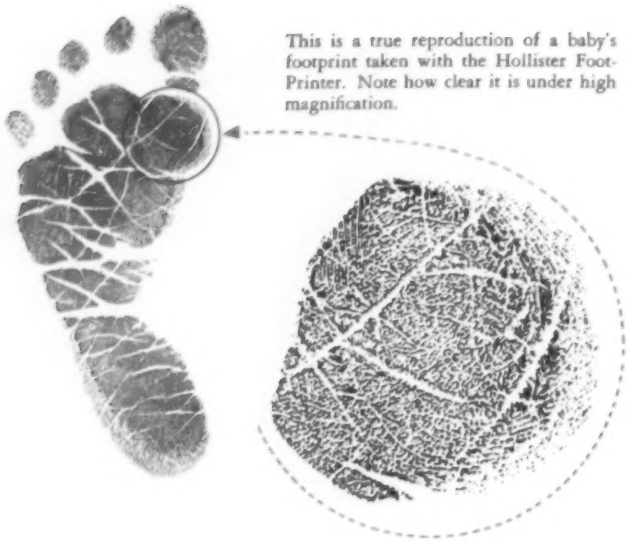
NAME _____ TITLE _____

HOSPITAL _____

STREET _____

CITY _____ ZONE _____ STATE _____

NOW... perfect footprints for your protection!



This is a true reproduction of a baby's footprint taken with the Hollister Foot-Printer. Note how clear it is under high magnification.

THE primary purpose of taking new-born footprints is to establish legal, lifetime identification, which protects the hospital by providing evidence of each new-born's identity. As the FBI has stated "The purpose of taking footprints is to provide a permanent record of individuality so that in the event a question should arise later as to the identity of the child and its mother, conclusive proof of its identity can be offered. The footprints of the infant, therefore, should be taken at birth."* Yet, even today, hospitals are taking thousands of baby footprints that have little, if any, identification value. This is because the old-fashioned methods that were originally designed to take prints of thick, coarse adult skin are being used to take prints of soft, delicate baby skin. This, of course, results in footprints that are heavy, filled-in blobs of ink, unsuitable for identification. And that is why the revolutionary Hollister FootPrinter was developed.

HOLLISTER

FRANKLIN C. HOLLISTER COMPANY
833 N. ORLEANS ST. • CHICAGO 10, ILLINOIS

Why is the new Hollister FootPrinter revolutionary?

First— it embodies an important, unique principle of taking prints — it uses a special dry plate instead of a wet and soppy ink pad or messy glass and ink roller. Instead of a thick coating of ink this new dry plate puts a light, very even film of color on the infant's microscopically fine skin. Then, when the print is taken, each tiny whorl and line can be clearly and perfectly reproduced.

Second—research proved that in order to get the perfect print made possible by the new dry plate method, the print had to be placed on paper that is smoother than the baby's fine skin. Ordinary paper isn't smooth enough to print an exact reproduction of the baby's fine skin. For this reason, prints taken with the Hollister FootPrinter are placed on glossy Kromekote paper, which furnishes lifetime identification for permanent hospital records. And further, Hollister-taken prints on Kromekote paper can be easily microfilmed because each little whorl and line is so clearly distinct.

Beyond this, with the Hollister FootPrinter nurses can take prints in seconds — instead of minutes. They do it by merely pressing the newborn's foot lightly against the sensitive dry plate — then taking the print. And that's all! It does away with the mess and bother of smeary tubes and messy pads of ink. And the baby's foot stays practically clean, as do the busy nurse's hands. There's no difficult wash-up of baby's foot. The dry plate fits snugly into a sturdy plastic case and will take 150 prints. Then, when the plate's color is used up, it can be discarded and replaced with a fresh plate.

Find out more about the revolutionary Hollister FootPrinter. Send in the coupon below for the illustrated brochure that fully describes it, and shows the new, low prices.

*FBI Law Enforcement Bulletin, January, 1945

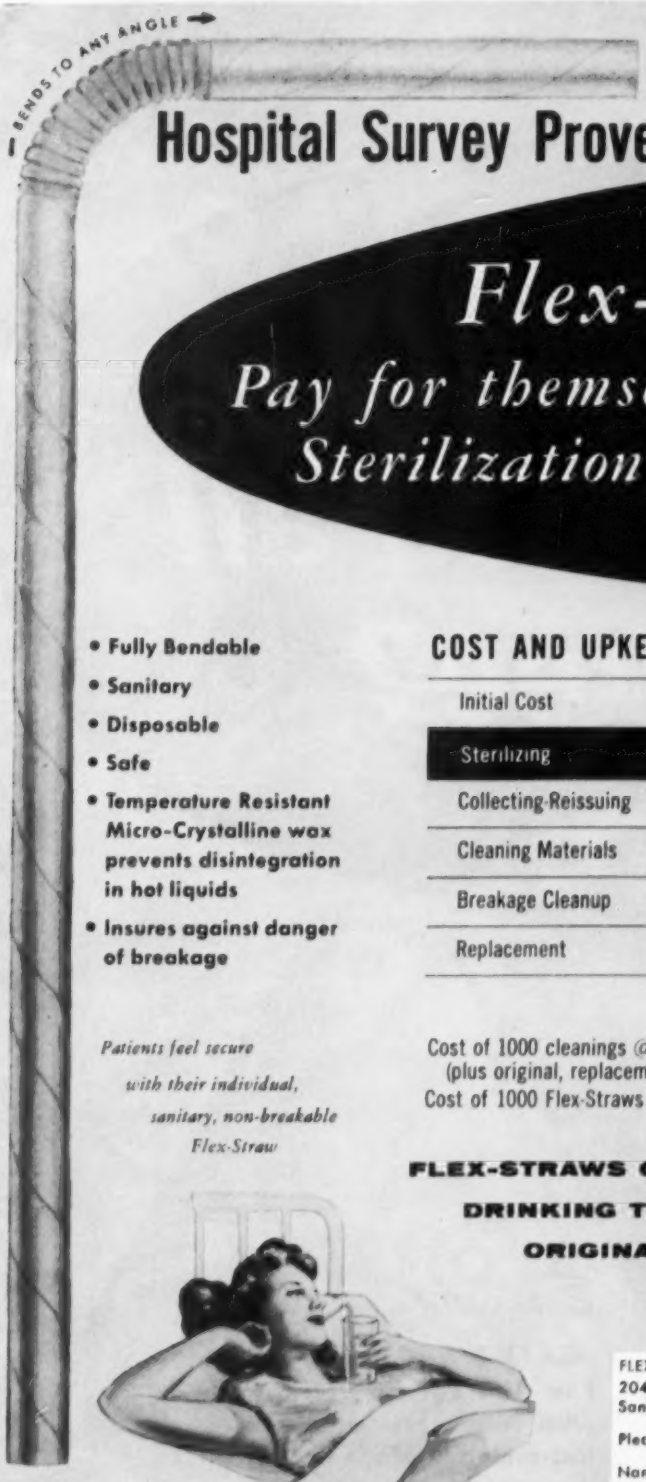
Please send to me, by return mail, the free illustrated brochure that fully describes the Hollister FootPrinter and shows the new, low prices.

NAME _____ TITLE _____

HOSPITAL _____

STREET ADDRESS _____

CITY _____ ZONE _____ STATE _____



Hospital Survey Proves...

Flex-Straws

Pay for themselves in Sterilization savings alone!

- **Fully Bendable**
- **Sanitary**
- **Disposable**
- **Safe**
- **Temperature Resistant Micro-Crystalline wax prevents disintegration in hot liquids**
- **Insures against danger of breakage**

Patients feel secure with their individual, sanitary, non-breakable Flex-Straw

COST AND UPKEEP—BREAKABLE TYPE TUBE

Initial Cost	Variable
Sterilizing	1/2¢ ea.* cleaning
Collecting-Reissuing	?
Cleaning Materials	?
Breakage Cleanup	?
Replacement	Variable

**Per survey based on minimum 75¢ per hr. labor cost*

Cost of 1000 cleanings @ 1/2¢ ea. $5.00
(plus original, replacement cost, etc.)
Cost of 1000 Flex-Straws ..... *(one case quantity)* $4.50

FLEX-STRAWS COMPLETELY ELIMINATE DRINKING TUBE UPKEEP

ORIGINAL COST THE ONLY COST

SEND FOR SAMPLES

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2040 Broadway
Santa Monica, California

Please send samples and information

Name _____ Title _____
Hospital _____
Address _____
City _____ Zone _____
State _____

Canadian Distributors:
INGRAM & BELL LTD.
Headquarters: Toronto

Have you tried all three?

"Specialist"®

EXTRA-FAST-SETTING

For clubfoot, fore-arm and other casts where an extremely fast-setting bandage is desired.

2" x 3 yd. 4" x 5 yd.
3" x 3 yd. 5" x 5 yd.
4" x 3 yd. 6" x 5 yd.
6" x 3 yd.

For walking-boots, long-term casts—and wherever maximal strength, minimal weight and effective moisture-resistance are essential.

3" x 3 yd.
4" x 3 yd. 6" x 3 yd.
4" x 5 yd. 6" x 5 yd.

"Specialist"®

FAST-SETTING

The bandage of choice for all general cast work.

2" x 3 yd. 5" x 5 yd.
3" x 3 yd. 6" x 5 yd.
4" x 5 yd. 8" x 5 yd.

Johnson & Johnson

with GPL  *HOSPITAL TV*

one nurse observes a dozen patients *in seconds*

By just flicking a switch, a nurse can keep an eye on all patients—in private rooms and in wards—when her floor is equipped with GPL *ii-TV*. The bright, clear pictures that GPL's *industrial* and *institutional* television system brings to the receiver on her desk give her bedside reports as often as she needs them. Both improved patient care and staff efficiency are gained with this revolutionary, visual communications tool.

The small *ii-TV* camera, weighing only five pounds, is easily moved wherever needed. Yet it is so sensitive it gives fine pictures despite the low light level of hospital rooms. The camera can be equipped to sweep a whole ward, to operate from remote control, to supply a close-up at will.

Any number of rooms can be put on an *ii-TV* circuit and nurses can operate the entire system. Maintenance is simple. Initial cost is low.

Patient observation is only one of the many hospital jobs *ii-TV* can do. A GPL *ii-TV* System makes it possible to keep records in a remote basement, yet visually accessible, instantaneously. Students and trainees, watching on an *ii-TV* monitor, get a far better view of treatments, an operation or a teaching demonstration than they can when watching through a porthole, or in a classroom or operating theatre. Tie a GPL TV projection set into the *ii-TV* circuit—as a Midwest mental clinic has done recently—and a whole auditorium can watch larger-than-life pictures on a wall-size screen.

GPL *ii-TV* is also invaluable in keeping an eye on entrances, corridors, storerooms. The GPL camera will keep unceasing watch at key points and report to a central monitor.

Behind *ii-TV* are the skill and experience which have made GPL one of the country's leading manufacturers of broadcast, theatre, military and industrial TV equipment. The same design skill, high quality material and precision manufacture go into the GPL *ii-TV* System.

For more information as to how your hospital can use GPL *ii-TV* to improve both patient care and operating efficiency, write:

General Precision Laboratory Incorporated
Pleasantville, New York

A SUBSIDIARY OF GENERAL PRECISION EQUIPMENT CORPORATION

HERRICK STAINLESS STEEL* REFRIGERATORS

Unmatched for Dependable Performance

Highest quality materials and fine craftsmanship combine to make HERRICK Refrigerators completely dependable. Low cost, year-after-year performance is assured, as are rugged durability and maximum convenience. Write for the name of your nearest HERRICK supplier. He is ready to serve you.

*Also available with white enamel finish.

They both agree . . . HERRICK trouble-free performance is tops.

HERRICK Model TSS66
Top-Mounted Reach-In

HERE'S WHY:

- **Oversize Cooling Coil** — Provides correct temperature and humidity. Assures faster recovery and uniform temperatures throughout the refrigerator for superior results.
- **Heavy-Duty Condensing Unit**—Properly balanced with cooling coil for maximum life and service.
- **Large Compressor Compartment**—Contains sufficient ventilation openings to give best condenser cooling.
- **Super-Efficient Insulation**—Semi-rigid Fiberglas 2½ lb. density, 3" thick in walls, 3⅝" thick in doors.

...plus many other HERRICK Extra-Value Features. Ask about them.

Typical Installations

HERRICK Refrigerators are Performance-Proved at:

St. John's Hospital
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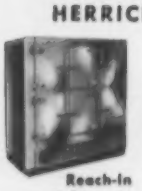
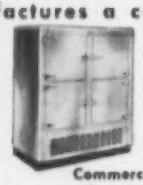
HERRICK manufactures a complete line of:



Reach-In Refrigerators



Commercial Freezers

Walk-In Coolers

HERRICK REFRIGERATOR COMPANY • Waterloo, Iowa
Dept. H., Commercial Refrigeration Division

The portion-control answer to ketchup problems*

NEW KRAFT PC* PACK KETCHUP

Individual plastic containers
eliminate waste and assure exact portions,
measured costs and convenience.

Kraft's newest PC Pack product—individual air-tight containers of top quality ketchup—will efficiently solve your ketchup-serving problems. PC Pack ketchup not only eliminates *waste* but also delivers additional *plus* advantages.

ALSO AVAILABLE—PC Packs of finest jams and jellies in 6 popular varieties—packed in ½-oz. size and maple-flavored table syrup in 1½-oz. size.

KRAFT FOODS COMPANY
500 Peshtigo Court • Chicago 90, Illinois

The nation's taste is your best buying guide

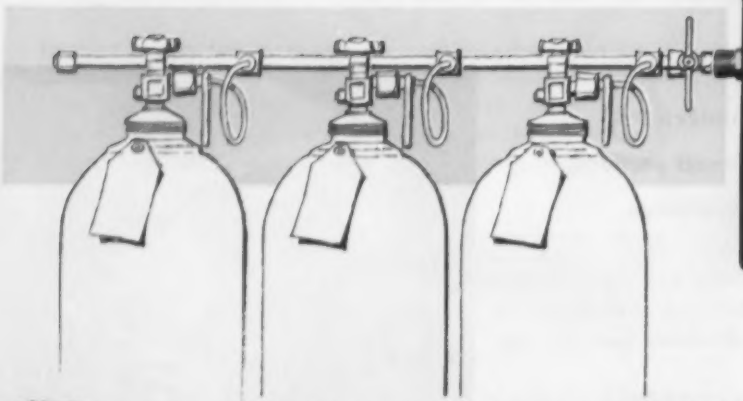
MEASURED COSTS—No guesswork as to costs per serving *and* you always know how many servings you have on hand.

CONVENIENT—No work involved with PC's—all you have to do is place it on the plate. It reaches customer in a neat, sanitary condition.

EXACT SERVINGS—Each PC is a just-right serving. Neither too skimpy to cause customer complaints . . . nor too generous to cut into profits.

PACKED FOR EFFICIENT HANDLING—Packed 20 to a tray—10 trays to a carton. Will store compactly in a minimum of space.

the pipe dream



NCG No. 272 AUTOFLOW*
Manifold Control Unit

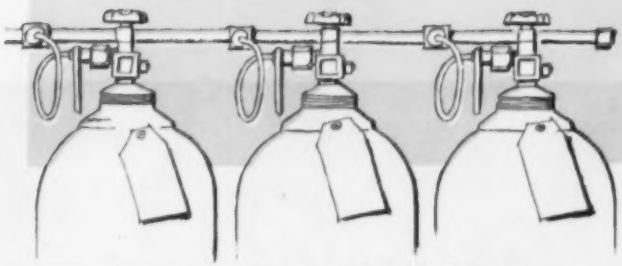
"It's here, Doctor . . . our **AUTOFLOW!** *No levers, no buttons, no resetting—it automatically switches from service bank to reserve bank. Gives us the security we always hoped for."*

*AUTOFLOW is a Trademark

Complete Hospital

When people think of piped oxygen, they usually think of NCG first—and the famous NCG "firsts". For NCG originated the "electrical box" type outlet, the manifold control unit, and many other types of equipment that have become the standard. But it is the comprehensive service—from installation to inhalation—that has earned NCG the confidence of hospital authorities from coast to coast. More than one thousand hospitals attest to the quality of NCG piped oxygen systems and service. If your hospital does not have a piped

that came true



When hospitals first began to install piped oxygen systems, the big dream was a *completely automatic* manifold control unit.

Well, it's here . . . and sooner and better than the most optimistic had hoped for. The new AUTOFLOW control unit automatically switches from supply bank to reserve bank of cylinders, with no pressure fluctuation.

There are no levers, no buttons--all controls in the unit are completely automatic, all are located *inside* the cabinet for maximum security and assurance against tampering or accidental misadjustment. There is no resetting, no manual action required at any time, except the replacement of empty cylinders.

Although the AUTOFLOW control is the safest, most accurate, most fool-proof manifold control unit yet devised—created by the company that created the *first* manifold control unit specifically for hospital use—it is provided with every safety device. Light signals tell which bank is in use. Pressure gauges tell exact volume of oxygen in right and left bank of cylinders. The control for the alarm system is built in, and a green light—on at all times—assures that the electrical power supply is working.

The AUTOFLOW is a complete self-contained unit that requires no assembly for installation, and maintenance is at a minimum. It is listed under the Re-examination Service of Underwriters' Laboratories, Inc., and conforms to NFPA standards.

Piping Systems

oxygen system, our representatives will be happy to show you how a piped oxygen system will add safety and convenience to the administration of oxygen to your patients. Moreover, it will pay for itself, and then continue saving money for you in the future. Write for information.

No. 238-50
Oxygen Outlet

NCG®

MEDICAL DIVISION

NATIONAL CYLINDER GAS COMPANY

840 North Michigan Avenue • Chicago 11, Illinois

Branches in 56 Cities

How Ceco-Sterling **Standard Window**

Frankel and Curtis, architects/Ben Eubank Lumber Company, contractor

Sections *filled a special need...*

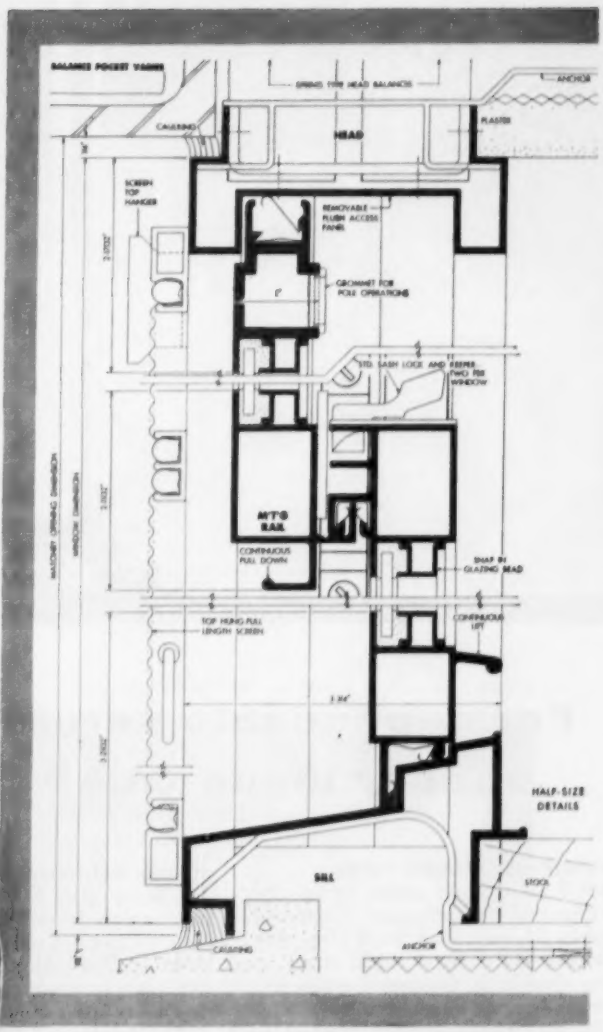
architectural effect achieved... budget balanced... maintenance cost reduced

An exacting set of conditions faced Architects Frankel and Curtis in designing Central Baptist Hospital, Lexington, Kentucky. There was the matter of money . . . budget limited . . . minimum maintenance a must . . . on-time delivery imperative. Windows were required to fit modern hospital routine—and to blend traditional design with contemporary atmosphere. The architects specified Ceco-Sterling Windows and Screens, for they met the need on all counts. Reasons:

1. Standard window sections gave the wanted architectural effect . . . heavy special sections avoided.
2. Sash operate silently . . . float on stainless steel weatherstripping.
3. Double-hung windows are suited to hospitals . . . ventilation controlled top or bottom.
4. Easy to screen . . . narrow frames admit more light.
5. Easy to clean . . . sanitary . . . "no painting" cuts maintenance $600.00 per year.

Delivery was made on time and in time to meet building schedules. Here is another example of Ceco serving on the architect-contractor-owner-supplier team, helping provide the desired structure at a saving. Next time call on Ceco when you have a building problem. CECO STEEL

Ceco-Sterling 200-B Double-Hung Aluminum Window and Half-Size Details



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CECO ENGINEERING
makes the big difference

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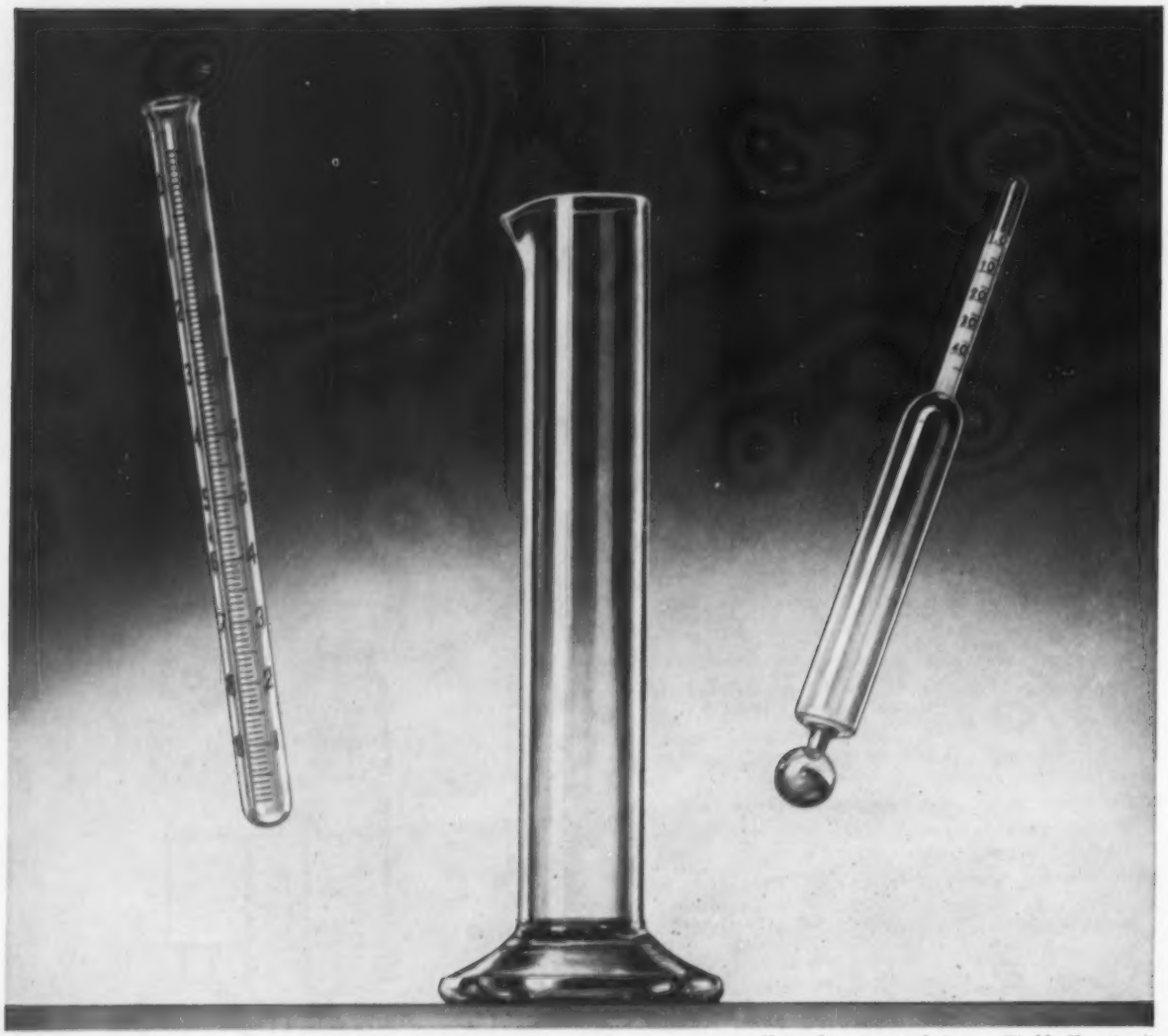


Shown here in actual size are Kimble Hematocrit Tube #46749, Glasco SMALL Urinometer Set #765.

For dependable serological and urine tests specify these GLASCO laboratory items

KIMBLE HEMATOCRIT TUBES:
You'll never worry about "losing" the calibrations on these new Hematocrit tubes. Kimble uses a "color filler" that is as resistant to chemical attack as the glass itself. Graduated scales will never become illegible, regardless of the way the tubes are washed or handled.

GLASCO SMALL URINOMETERS:
Now you can use as little as 15 ml. of urine with complete test accuracy. The heavy glass foot of the cylinder is accurately leveled by grinding and insures against easy tipping. The mercury-filled hydrometer is retested to allow a maximum tolerance of plus or minus .002 specific gravity. It remains stable and upright even in solutions where specific gravity is close to 1.000.

Every Hematocrit tube and urinometer is individually tested and retested to be sure of its accuracy. All are thoroughly annealed to increase mechanical strength.

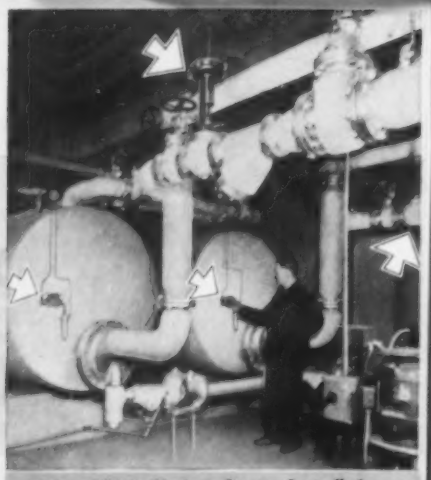
There is a Glasco item for every laboratory requirement. Order from your hospital supply house, or write direct to us for a free copy of our latest catalog and price listing.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

Powers Thermostatically Regulated Showers

Continuous Flow Bath—Note Powers Control Cabinet



Large Water Heaters—Powers Controlled

HINSDALE, ILL. SANITARIUM AND SHOWS DIVERSITY OF POWERS

★ FOR HEATING ★ AIR CONDITIONING ★ WATER HEATERS ★ HYDRO-THERAPY ★ SHOWER BATHS

Few 200 bed institutions are as well equipped to save and prolong lives as Hinsdale's Sanitarium and Hospital

It's six operating rooms, X-Ray department (including a 250,000 volt deep-therapy machine for cancer treatment), delivery rooms, beautiful nursery and obstetrical department are all equipped with the best modern equipment.

Outstanding Polio Treatment Center. Facilities here can accommodate up to 30 polio patients and keep them in complete isolation. Three iron lungs, rocking beds, steam rooms and many types of hydro-therapeutic baths under the care of skilled attendants provide patients with the best service obtainable.

Comfort and Safety of Patients here is assured by the dependability of Powers thermostatic controls used throughout the building.

When you want help in selecting the right type of control for hospitals or any other type of building, call in an experienced Powers engineer. There's no obligation. (bs)

THE POWERS REGULATOR COMPANY

SKOKIE, ILL. • Offices in Over 50 Cities in U. S. A., Canada and Mexico

OVER 60 YEARS OF AUTOMATIC TEMPERATURE CONTROL

Scotch Douche and Hydrotherapeutic Showers are Both Powers Controlled

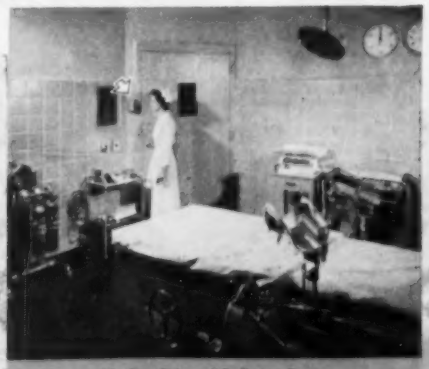
One of Three Iron Lungs in Children's Room

Steam Rooms Regulated by Powers Thermostats

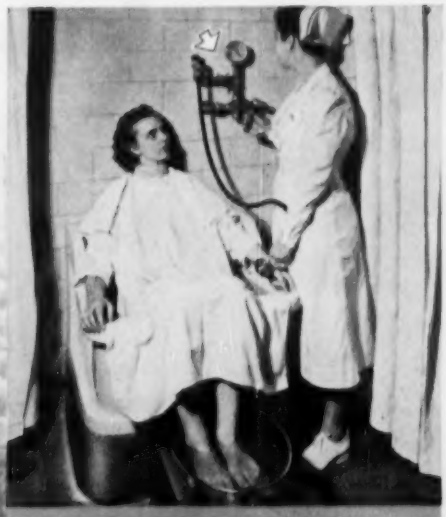
HOSPITAL TEMPERATURE CONTROL

Architects and Engineers: **Fugard, Burt Wilkinson and Orth • Edward G. Halstead**
General Contractor: **E. H. Marhoefer Jr. Co.**
Contractors: **Thomas J. Douglass & Co.** (Heating) • **Charles E. Gazin** (Plumbing)
Plumbing Fixtures: **American-Standard**
All of Chicago, Ill.

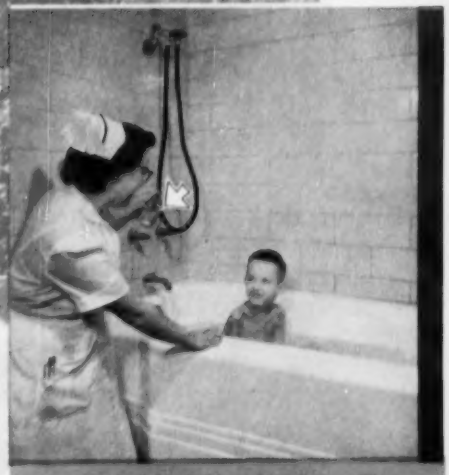
Deep Therapy X-Ray Room



Air-Conditioned Delivery Room



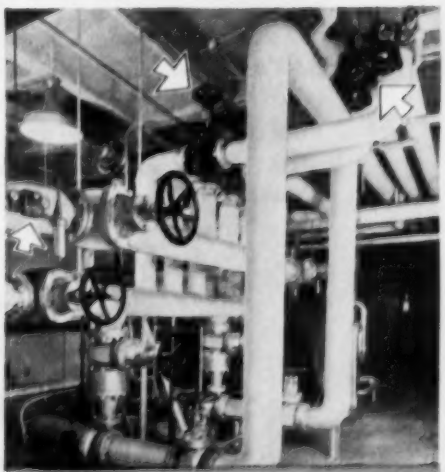
Powers Control on Sitz Bath with Raised Base



Treatment Bath for Children. Note Powers Mixer

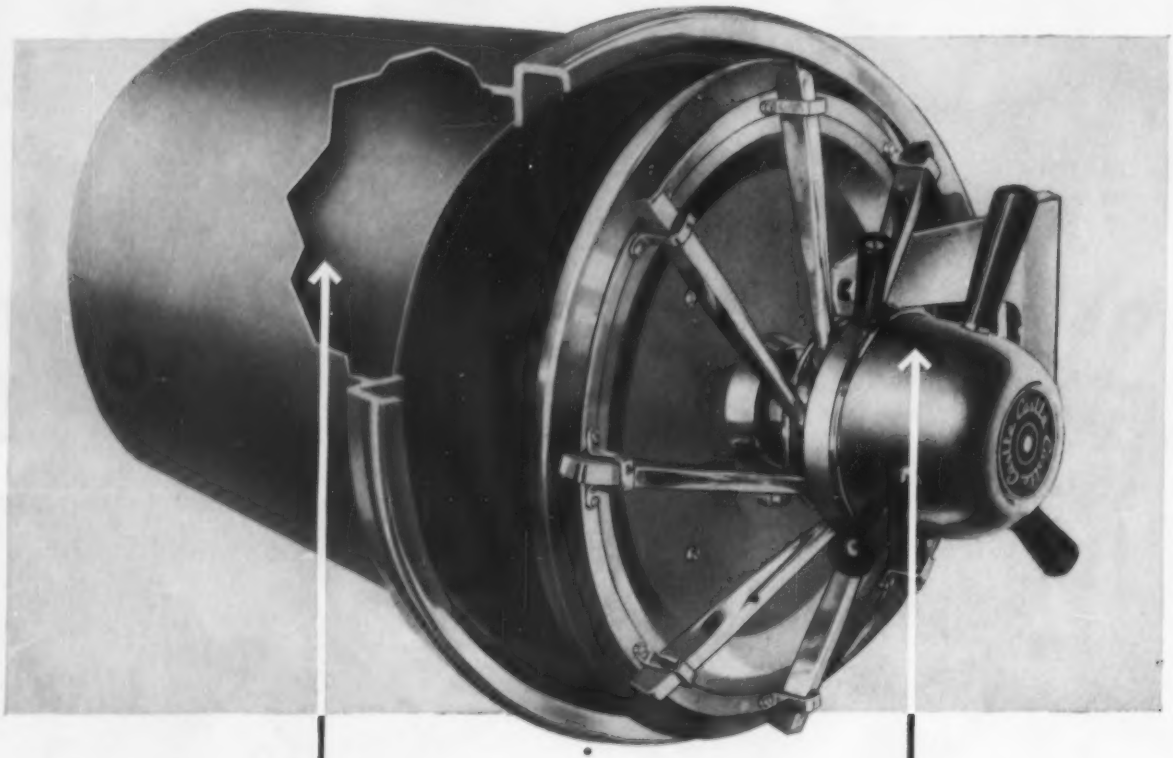
Section of Nursery

Powers Controlled Whirlpool Bath for Polio Patients



Controls on Forced Hot Water Heating System

AGAIN *Castle* MAKES STERILIZER HISTORY



FOR THE FIRST TIME,

a complete double-walled chamber . . . including the back plate area . . . permits a fuller distribution of steam which effects a more rapid heating of the load. Increases operating efficiency.

Both inner and outer shells are entirely Monel — an exclusive, as is the forged end ring to which they are both welded. No rivets to leak, no solder to loosen. Castle's all-welded construction provides greater strength, smooth surfaces without pits or crevices, lifetime resistance against rust or corrosive damage. Greater operating economy.

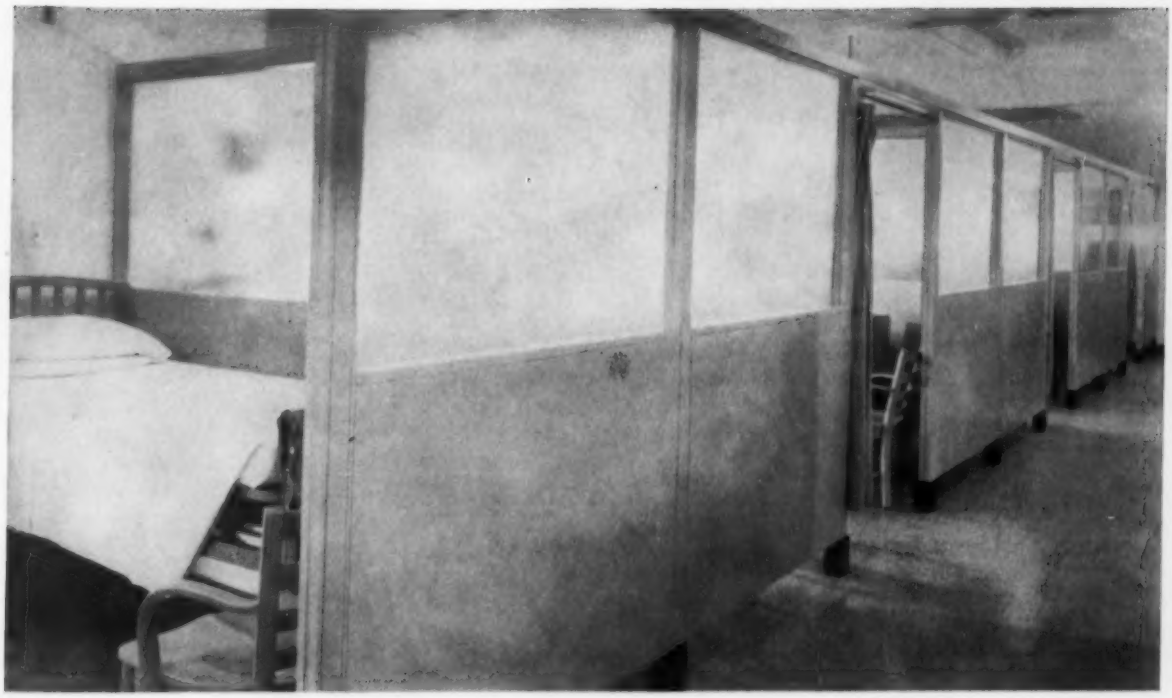
A DOUBLY-SAFE DOOR

1. Pressure diaphragm lock inside door and safety lock outside door give dual protection against premature opening.
2. A new ball-suspended DOOR HINGE for simplified horizontal, vertical and perpendicular self-centering corrections.
3. Noise-free ball-bearing THRUST MECHANISM. Recessed gasket in door for greater maintenance economy.

WRITE TODAY for complete details on Castle Planning, Engineering and Fabrication.

Castle LIGHTS AND STERILIZERS

WILMOT CASTLE COMPANY • 1700 E. HENRIETTA RD. • ROCHESTER, N. Y.



Demand for more semi-private and private rooms met by VMP Mobilwalls

To solve hospital partitioning problems, to increase income per bed, many hospital architects and contractors are using movable, metal VMP MOBILWALLS. These attractive, easy-to-clean partitions have proved ideal for new hospitals and for modernizing older buildings. They create more peace and privacy for patients, make more productive use of critical floor areas. With VMP MOBILWALLS you get quicker installation, greater convenience, superior sound reduction, better appearance, more reliable service. Write, or ask VMP to show you how to improve your floor plan!

SUB-DIVIDE WARDS with MOBILWALLS, and watch the value of each bed increase! A VMP installation can pay for itself in four months, increase yearly income by $35,000.

NEW DESIGN, INCREASED RIGIDITY, FEWER PARTS are features of redesigned Royal Flush MOBILWALLS. Use this new design to increase dignity and simplicity of offices.

TRAINED VMP CREWS install the attractive partitions in a few hours, do the job rapidly and efficiently. There's no dirt or fuss—no need for carpentry, plastering or painting.

Virginia Metal Products, inc.

ORANGE, VIRGINIA

Subsidiary of Chesapeake Industries, Inc.

NEW VMP PARTITIONING HELPS FOR HOSPITAL MANAGEMENT!

Virginia Metal Products, Inc.
Orange, Virginia

- ☐ Have nearest VMP partitioning specialist see me.
- ☐ Send new folder "How to Solve Hospital Partitioning Problems."
- ☐ Send folder "Simplified Office-Area Planning with Ratio-Delay Studies and VMP MOBILWALLS," and manual.

Send VMP descriptive literature:

- ☐ New RF Royal Flush MOBILWALLS
- ☐ MOBILWALLS in Schools
- ☐ New VMP MOBILWALL Jrs.
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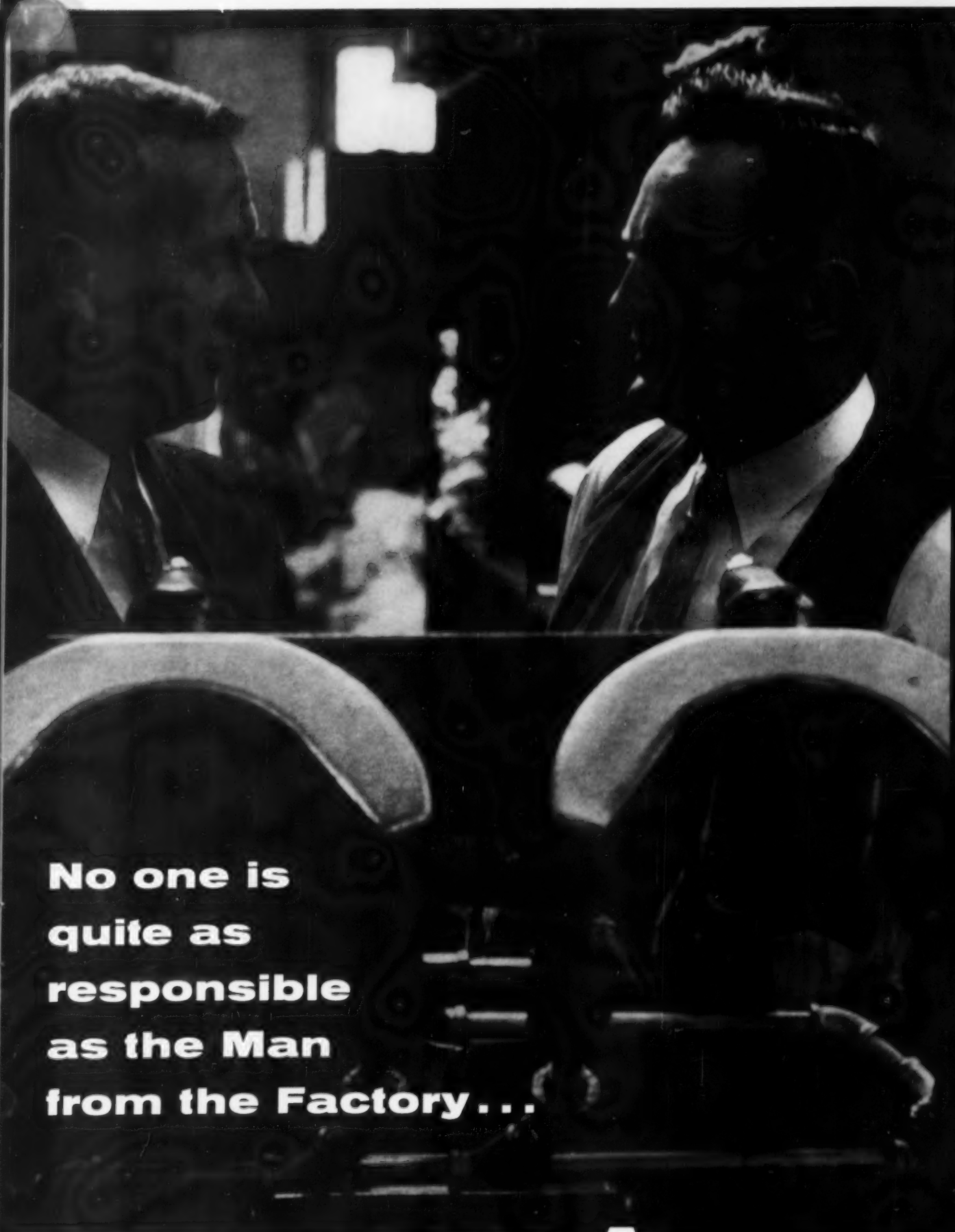
- ☐ VMP MOBIL-FIRE-WALLS
- ☐ VMP Conveyor Systems
- ☐ VMP Library Shelving

Name_____ Title_____

Hospital_____

Address_____

City_____ Zone____ State_____



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Your nearby American representative is always a Man from the Factory

Through him, you can get expert help with production problems, prompt service for your machines, professional assistance in training machine operators, helpful financing for expansions and improvements in your business. Every day, he sees how others solve problems like yours. He is a valuable contact with your industry, a source of news and information.

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His first responsibility is to serve you. You can expect more of him, because he is the man from the factory.

You can expect more from . . .

American

The American Laundry Machinery Company, Cincinnati 12, Ohio

MEET THE "HIT" OF THE AHA and ADA CONVENTIONS

the NEW MEALPACK "REDI-SERV" SYSTEM

Ideal, Low Cost Tray Service for Hospitals up to 75 Beds

CHECK THESE **MEALPACK** EXCLUSIVE "REDI-SERV" FEATURES!

- Requires no electric preheating; therefore hot foods *do not dry out*. No costly heating elements to operate and maintain. Completely adaptable to repeat trips for serving up to *63 beds per cart per meal* (in 3 trips). One Traycart does the work of *three!*—yet each tray is instantly *ready to serve*.
- Hot and cold liquids (soups, beverages, special liquid diets) are *portion-controlled* at main kitchen, then protected for *each patient* in ideal condition by Mealpack's new insulated, stainless steel Model 15-12 Individual Beverage Server; or with heat retaining cups and soup dishes fitted with vacuum sealing lids.
- Each entree (meats, fish, gravies, vegetables) maintain *savory kitchen freshness and heat* by vacuum seal in Mealpack's Container up to 2 hours after packing.
- Every tray is complete, ready to serve after setting —yet *positively* protected against food deterioration.
- No tray completing at serving point! Complete control at kitchen insures dietary accuracy.
- All foods for every tray—special, selective or general diets—are controlled at *main kitchen*. No more *serving mistakes!*
- Easy to clean! No disassembly, no corrosion, no wiring or heating elements to damage.
- Unique "locking" type sliding doors protect all tray contents between main kitchen and serving points.
- Popular Mealpack "five point" precision caster suspension facilitates easy handling, storage and operation in cramped or limited corridors, kitchens, elevators, etc.
- Sanitary, sturdy, "lifetime" welded stainless steel construction. Nothing to maintain.

If you now operate up to 75 beds—or if you're building or expanding to that capacity—the Mealpack "Redi-Serv" System is the answer for faster, lower cost, trouble free food service for *every* patient!

This new "Redi-Serv" traycart system with Mealpack Containers, gives you *positive protection* food quality for every tray, every floor, every time!

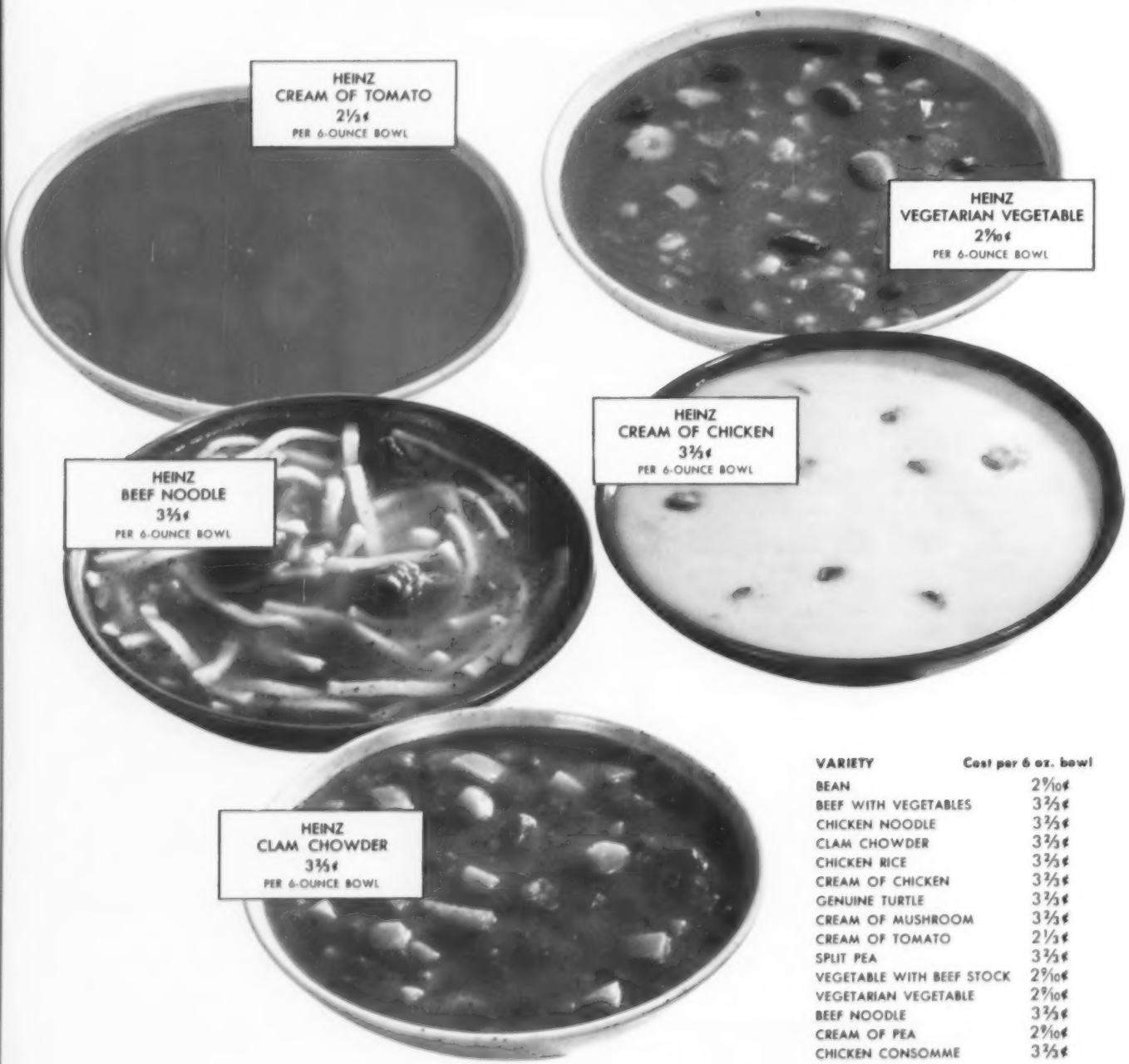
Already, Mealpack's unique vacuum protection has solved baffling dietary problems in countless hospitals. Now, the illustrated 21 tray "Redi-Serv" traycart offers Mealpack's advantages at a *new low cost* any small hospital can afford.

Investigate these advantages for your hospital! Write us today!

MEALPACK CORPORATION · EVANSTON, ILLINOIS

hot foods hot **mealpack** *cold foods cold*

COMPARE AT YOUR PRESENT



VARIETY	Cost per 6 oz. bowl
BEAN	2⁹⁄₁₀¢
BEEF WITH VEGETABLES	3⅓¢
CHICKEN NOODLE	3⅓¢
CLAM CHOWDER	3⅓¢
CHICKEN RICE	3⅓¢
CREAM OF CHICKEN	3⅓¢
GENUINE TURTLE	3⅓¢
CREAM OF MUSHROOM	3⅓¢
CREAM OF TOMATO	2½¢
SPLIT PEA	3⅓¢
VEGETABLE WITH BEEF STOCK	2⁹⁄₁₀¢
VEGETARIAN VEGETABLE	2⁹⁄₁₀¢
BEEF NOODLE	3⅓¢
CREAM OF PEA	2⁹⁄₁₀¢
CHICKEN CONSOMME	3⅓¢

OUR EXPENSE--
SOUP WITH HEINZ

1. COMPARE THE FLAVOR...2. COMPARE THE COST—THEN...3. DECIDE IF MAKING SOUP IS WORTH YOUR CHEF'S VALUABLE TIME!

WE'LL SEND YOU A FREE CHEF-SIZE TIN of any of the 12 Heinz soups. All we ask you to do is heat—open—taste—compare with the soup you now serve!

FIRST COMPARE FLAVOR. That's simple. If you don't like Heinz *at least* as well as your present soup, don't go any further. Heinz soups are made of ingredients the finest kitchen would be proud to use. They're seasoned and cooked under the supervision of Master Chefs. Taste and see for yourself!

THEN COMPARE COST. Many kitchens do not know their actual cost on soup because so many of the costs are *hidden*. It's easy to measure the cost of ingredients but how about these hidden costs:

Labor costs . . . Chef's time . . . fuel . . . spoilage and leftovers . . . tied-up cooking equipment

These costs cannot be figured exactly, but they *are* costs and should be considered.

COMPARE AND SEE FOR YOURSELF. Let your own taste and your own costs decide. Fair enough? Fill in the coupon and mail it for your free Chef-Size tin of Heinz Soup *now!*

HEINZ 57 SOUPS

YOU KNOW IT'S GOOD BECAUSE IT'S HEINZ

Heinz 51-oz. Chef-Size Soups are condensed . . . one tin makes two.

FREE CHEF-SIZE TIN OF HEINZ SOUP

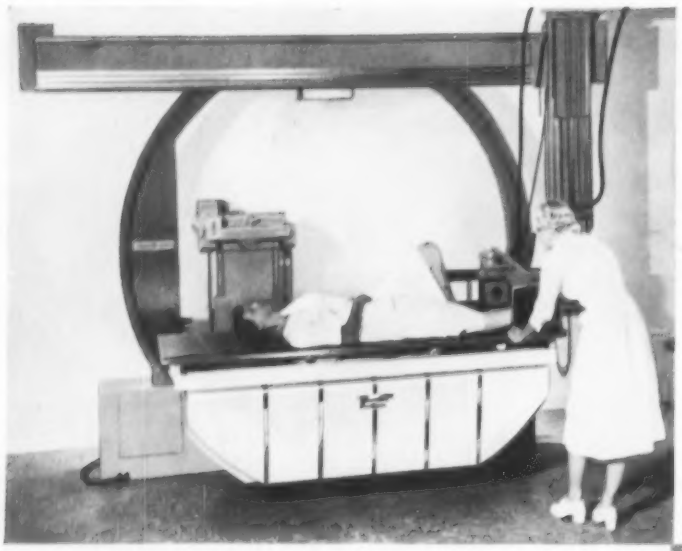
H. J. Heinz Co., P. O. Box 57, Dept 28, Pittsburgh 30, Pa.
I'll compare and see for myself. Send me a free Chef-Size tin of Heinz Condensed Soup (makes 102 ounces of soup).
Variety _____
(any soup you choose)

Name _____ Position _____

Affiliation _____

Street _____

City _____ Zone _____ State _____



A 500-MA IMPERIAL

FOR JUST $20.00 A DAY

Yes — for this "working day" sum, you can enjoy all the advantages of a deluxe Imperial 500-ma diagnostic x-ray unit, complete with spot-film device and phototiming.

A 200-MA MAXICON®

FOR JUST $7.50 A DAY

Truly professional facilities are afforded by this 200-ma, full-wave rectified, single-tube (over-under-table), hand-tilt diagnostic x-ray unit — yours for this small rental charge.

RENT
the x-ray apparatus you need through
G-E MAXISERVICE®

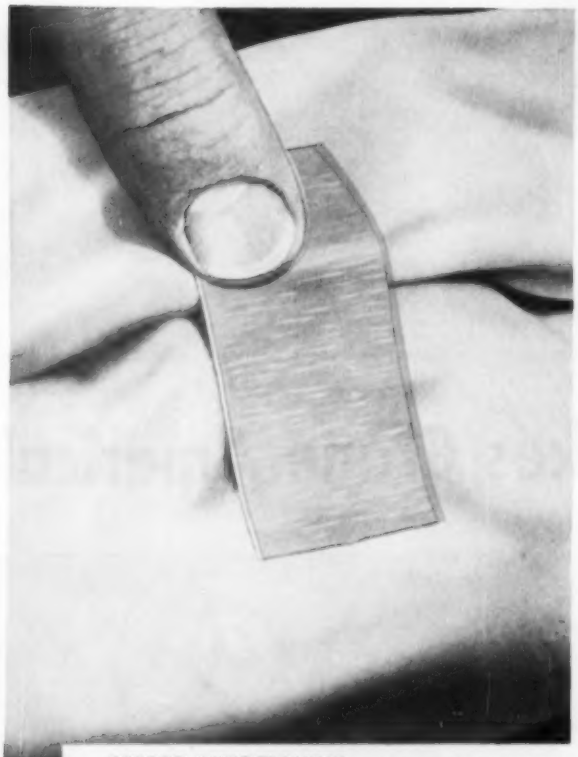
MANY factors affect the economics of x-ray equipment ownership. By actual cost analysis, you may find that General Electric's Maxiservice Rental Plan is exactly what you need.

There's no initial capital investment. You get modern apparatus equipped for the latest technics. More than that, this apparatus *stays* up to date, thanks to periodic replacement option. A single, monthly rental charge includes repair parts, tubes, maintenance and local property taxes. Your rental can be budgeted as operating expense against income from the apparatus.

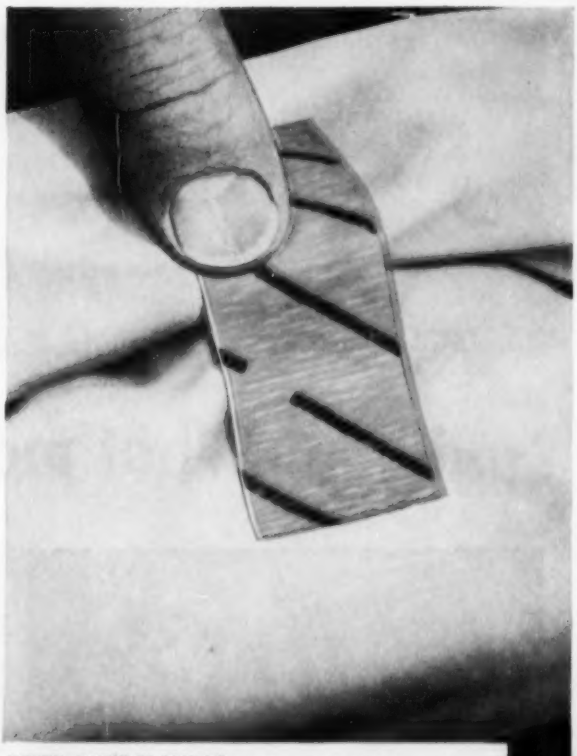
Your G-E x-ray representative will be glad to give you facts and figures. Or write to X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for Pub. H-21.

Progress Is Our Most Important Product

GENERAL ELECTRIC



BEFORE AUTOCLAVING. Here is what "SCOTCH" Brand Hospital Autoclave Tape looks like on bundles ready to be put in the autoclave.



AFTER AUTOCLAVING. These unmistakable markings tell you the pack has been through the autoclave. There is no possibility of error. The special inks used in this tape must be *intentionally activated,* and

Only high steam temperatures can do it!

No danger that sunlight or radiator heat will bring out the distinctive stripes on this foolproof tape. When you see them on an autoclave pack (and they can be seen clear across a room) you're sure that pack has been through the autoclave. *This is not positive proof of sterility, of course—nothing on the outside of a bundle can prove that.*

Seals packs firmly in half the time required for pinning, tying, or tucking! "SCOTCH" Hospital Autoclave Tape No. 222 holds in high steam temperatures, leaves no stains or gummy residue, can be written on with pencil or ink.

REG. TRADEMARK
SCOTCH
BRAND

Hospital Autoclave Tape No. 222

Your surgical supply dealer has this time-saving, work-saving tape now . . . See him right away!

The term "SCOTCH" and the plaid design are registered trademarks of Minnesota Mining and Mfg. Co., St. Paul 6, Minn. Export Sales Office: 99 Park Ave., New York 16, N.Y. In Canada: P.O. Box 757, London, Ontario.

CRANE

leading specialist in hospital plumbing?

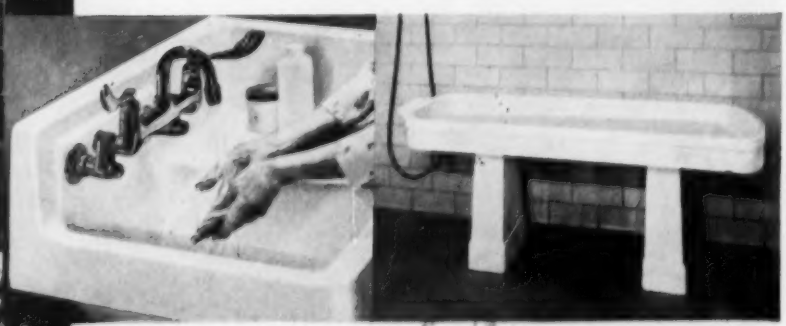
If you ask your architect, he'll probably tell you that Crane is the outstanding authority on hospital plumbing for two reasons:

1) Crane carries on continuous research, keeping abreast of the newest hospital techniques.

2) Crane uses this information to develop a complete line of fixtures as specialized for today's hospital as your x-ray equipment.

This means that when your hospital is Crane-equipped, it's as modern in its plumbing as in its radiological laboratories. Because every fixture is specially designed for its particular job, repair and maintenance problems, of course, are reduced to a minimum.

Why not talk to your architect about Crane. You'll find he agrees with your preference for Crane hospital fixtures.



Crane Hygiene lavatory designed especially for patients' and nurses' use. Has integral shelf for water pitcher, toilet articles and other patient needs. Six-inch-high end splash optional. Equipped with wrist-action Dial-ese controls for easy and positive operation. Crane Dial-ese means longer life—less maintenance.

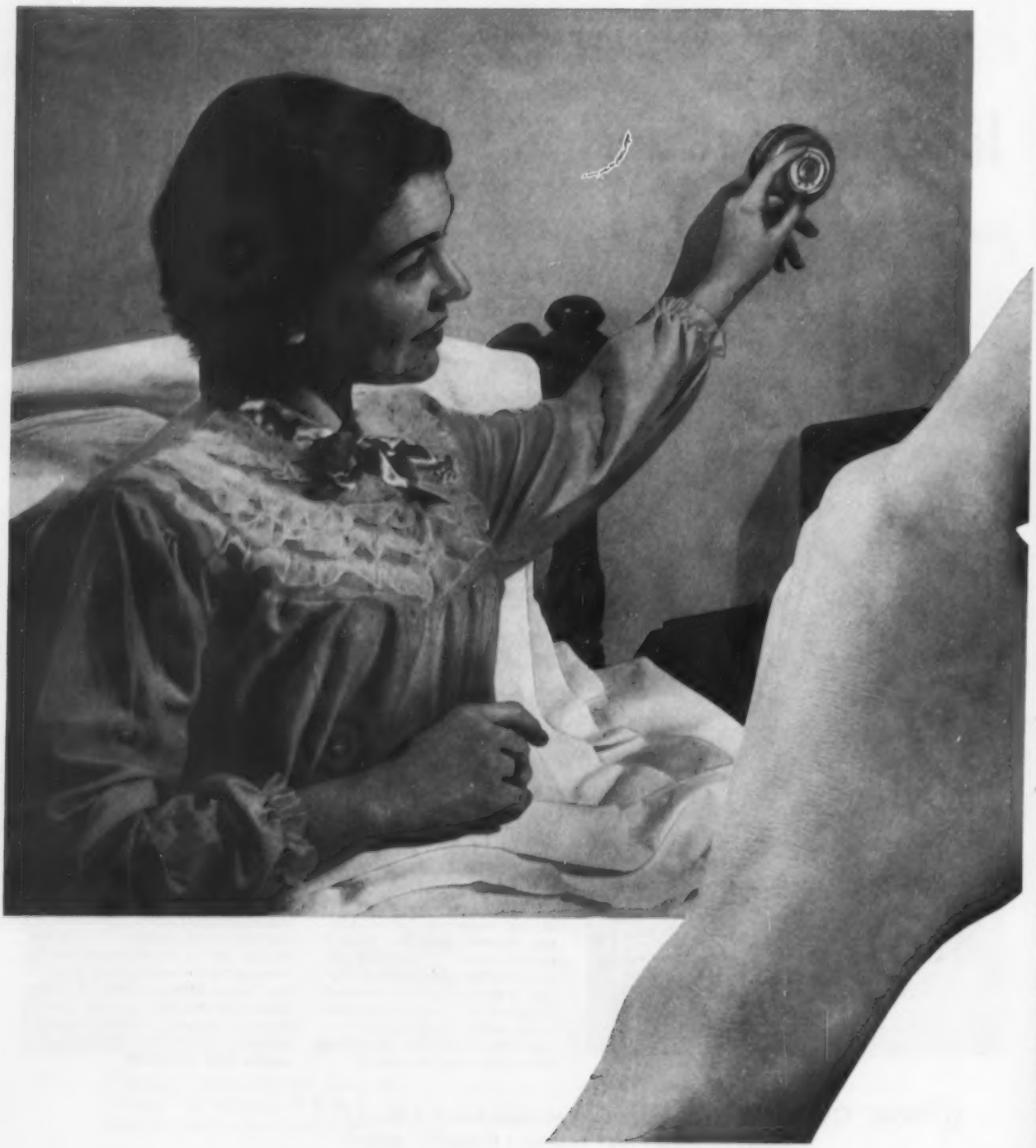
New from Crane. This emergency bath of Duraclay is one of the specialized fixtures developed by Crane for hospital use. Its shallow depth aids in movement of patient from and to litter. Has thermostatically controlled water supply with Deviator spout for diverting water to spray. Vacuum breaker safeguards sterile water supply against back siphonage.

CRANE CO. General Offices: 836 South Michigan Avenue, Chicago 5

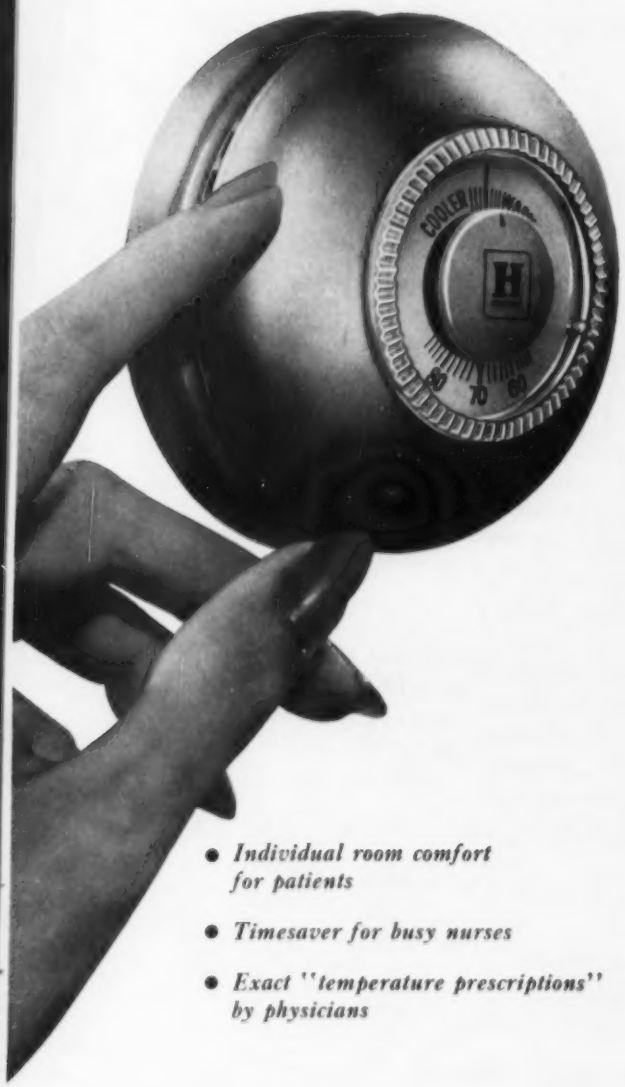
VALVES • FITTINGS • PIPE • KITCHENS • PLUMBING • HEATING

Real patient comfort is individual room comfort

HONEYWELL'S BEDSIDE



TEMPERATURE CONTROL



- *Individual room comfort for patients*
- *Timesaver for busy nurses*
- *Exact "temperature prescriptions" by physicians*

Honeywell Thermostat on wall of each room provides better therapy, more comfort for your patients, saves steps for busy nurses

HONEYWELL Bedside Temperature Control gives your patients fingertip adjustment of their own personal comfort. It frees your nurses from "chambermaid chores" such as opening and closing windows, carrying blankets from the storeroom, refilling hot water bottles.

Bedside Temperature Control also provides a saving in fuel costs by eliminating heating waste. It allows physicians and surgeons to "prescribe" exact room temperatures to help speed patient recovery.

The beautiful new Honeywell Round Thermostat is mounted for easy access by the patient. In 2-bed rooms it is mounted between the beds where temperature can be adjusted by either patient.

Bedside Temperature Control can be installed quickly and easily in new or existing hospitals. No tearing out of walls or redecorating is necessary. For more information, call your local Honeywell office now. Or write Honeywell, Dept. MH-2-24, 351 E. Ohio Street, Chicago 11, Illinois.

MINNEAPOLIS
Honeywell

Hospital Room Temperature Controls

112 offices across the nation

Erythromycin in treatment of abscess

6/21/55 **DISCHARGE SUMMARY**

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

specific against coccic infections

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

with little risk of serious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 250 mg.), bottles of 25 and 100. Abbott

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

*Filmtab—Film sealed tablets; patent applied for.

Vina-Lux® .. armored beauty for hospital floors

Hospital floors can be beautiful as well as durable. In this modern hospital corridor-waiting room area, Vina-Lux provides a background of enduring beauty. This rugged, vinyl-asbestos tile is highly resistant to all kinds of foot and wheel abuse – cannot be damaged by greases and most commonly used acids and alkalis.

This versatile floor performs a multitude of other duties to make hospital flooring dollars work harder. Vina-Lux has a noise-quieting resilience that pays dividends in high-traffic areas. Its slip-safe surface adds sure-footed comfort underfoot. And because the surface is so super-smooth and tight, Vina-Lux effects substantial savings in maintenance, both in time and labor as well as materials. It will keep its clean beauty without waxing.

This modern plastic flooring can be used in your hospital at a lower cost per square foot per year than any other type of resilient flooring. Why not investigate the merits of Vina-Lux further before investing in hospital floors. A qualified representative will be glad to call on you at your request and at no obligation.

AZROCK FLOORING PRODUCTS

AZROCK PRODUCTS DIVISION • UVALDE ROCK ASPHALT CO.

Frost Bank Building • San Antonio, Texas

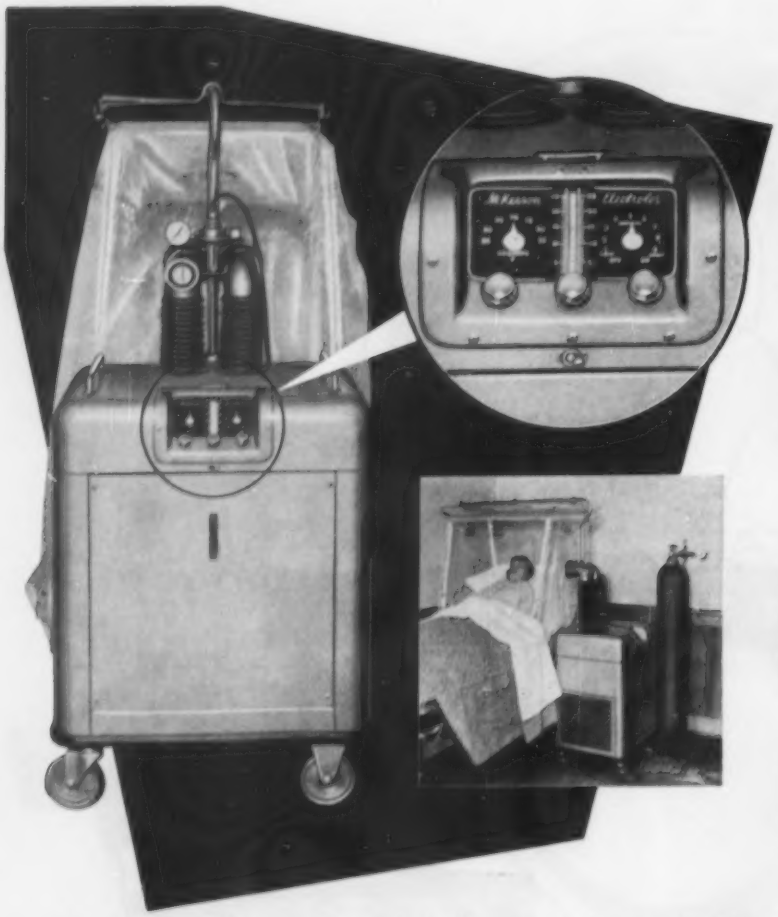
Makers of Vina-Lux • Azrock • Duraco • Azphlex

NEW . . . . Low cost adjustable aluminum railings for service stairs . . . comparable in price to aluminum pipe rail . . . competitive bidding by your local metal fabricators who build these railings from stock *TUBE-LINE* fittings and tubing . . . Blumcraft general catalogue M-56 available to Architects, or consult Sweets file 6e/Blu

TUBE-LINE®...LOW COST RAILINGS

Blumcraft® OF PITTSBURGH

460 MELWOOD STREET PGH. 13, PA. • PERMANENT DISPLAY 101 PARK AVE., N.Y.



LOW COST LOW UPKEEP

Compare McKesson Electrolor's features and price. Dollar for dollar, you'll see that its quality is the highest . . . its price the most reasonable.

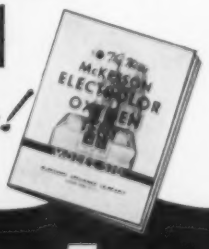
Then remember that, in most cases, there's *no* maintenance for years! And if there's any upkeep at all, it's nominal.

Add the exclusive feature that nurses may *read* Electrolor's inlaid panel *in the dark* without switching on lights and disturbing patients!

Now, don't you see why so many more Hospital Executives are ordering Electrolors every year?

Use genuine McKesson Canopies for best results!

Write Today for McKesson Electrolor Brochure!



McKesson ELECTROLOR Oxygen Tents

McKESSON APPLIANCE CO., TOLEDO, OHIO

Manufacturers of these major products—Bronchio Spirometry, Anesthesia, Resuscitators, Suction Pumps, Metabolism, Oxygen Tents, Analgesia, Vital Capacity, Pneumothorax, Air Compressors, Rocking Beds, Dermal Temperature, Oxygen Therapy

Here's One Reason Why

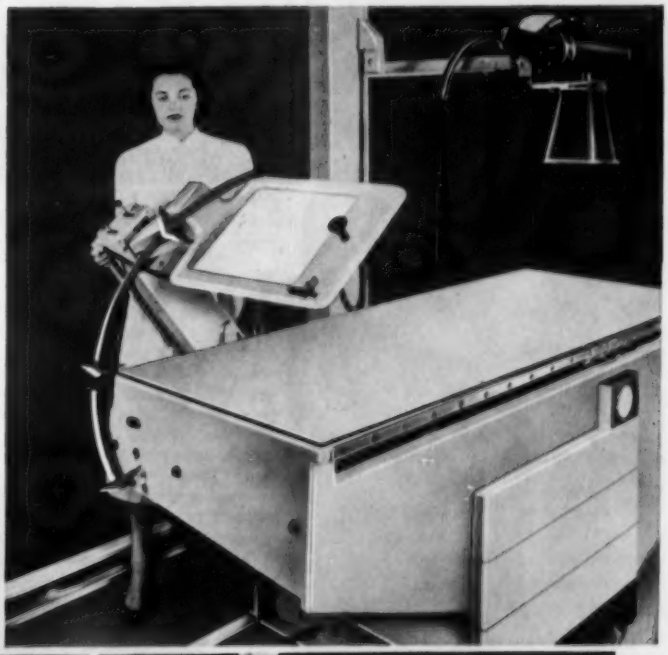
this Modern Diaflex X-ray Unit Outperforms All Others..

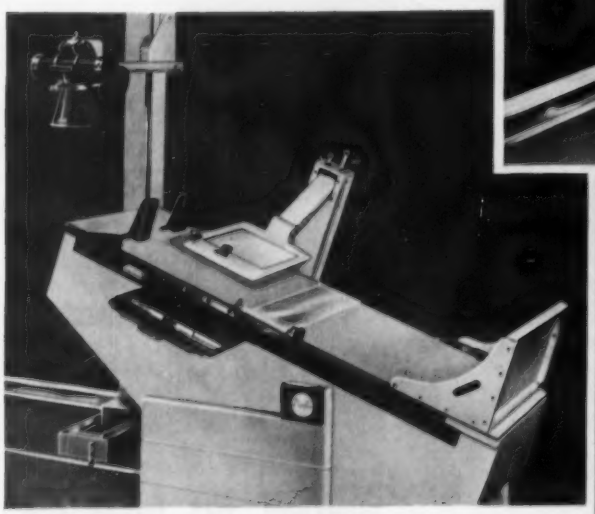
Diaflex incorporates exclusive "Hide-A-Way" parking of screen and tower. There is absolutely no interference from the screen and tower during important radiographic use. Result: Clear-Table Radiography as shown in photo at lower right.

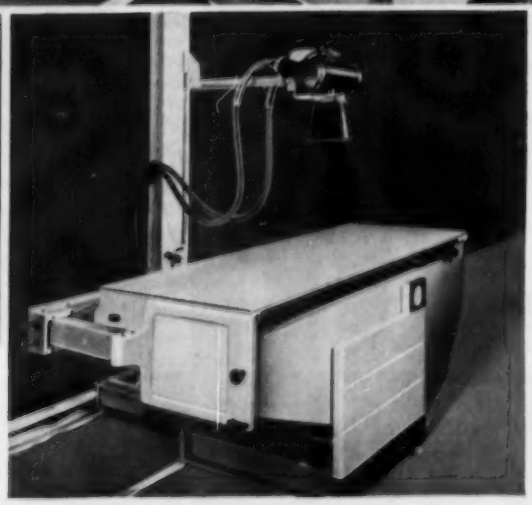
Tubestand moves beyond head and foot of table, permitting all angulation techniques. Fluoroscopic screen travel is exceptional. Excellent spot-film device, if specified, parks in the same manner as screen.

Diaflex is a single-tube or two-tube combination radiographic and fluoroscopic unit. It is ruggedly constructed and has a clean, modern appearance. Rich ivory finish.

Illustration below shows the Diaflex unit with adjustable foot-rest, shoulder-rest and compression device.







FREE BOOKLET
Before you buy any X-ray unit, compare the outstanding advantages of Diaflex. You'll find the cost is lower than you think. Write for this interesting and informative booklet.

YOU CAN BE **SURE**... IF IT'S

Westinghouse

MEDICAL X-RAY

Westinghouse Electric Corporation

X-RAY DIVISION

2519 Wilkens Avenue, Baltimore 3, Maryland

J-08317

SMALL HOSPITAL QUESTIONS

Need $100,000?

Question: I have recently heard it stated by an authority on hospital finance that a hospital of 100 beds should have a reserve for accounts receivable of $100,000. We do not have anything like this amount of cash reserve, and I am wondering if this is the correct figure. Can you inform us on this point?—E.A.T., Mo.

ANSWER: A recent survey of the accounts receivable situation in a small group of hospitals of various types in various parts of the country indicates a wide variation in accounts receivable practice. In this group of hospitals, the average reserve on hand to finance receivables was approximately $1000 per patient. The lowest amount was $700 per patient and the highest amount, $1800 per patient. This figure is obtained by dividing the average amount of accounts receivable by the average daily census.

By contrast, hotels in the same towns with the hospitals surveyed in this group had only $50 to $125 per guest as a reserve to finance accounts receivable.

Apparently few hospital trustees and medical staff members realize that the hospital needs capital with which to finance accounts receivable. Even businessmen on hospital boards who are accustomed to business requirements for working capital often neglect to consider the hospital's need for working capital. Lack of understanding of this aspect of hospital finances has been responsible for the widespread practice of requiring payments in advance from hospital patients—a practice that has certainly resulted in poor public relations for hospitals.

Certainly, hospitals should handle credit problems with as much intelligence as do department stores or other businesses. In most cases, it is possible to get advance credit information, either through the family physician or through commercial credit channels, on patients who make reservations in advance—so that only those who are known bad credit risks need be asked for advance payments. In turn, the hospital should make its own credit information available to doctors so that they may be better informed on the family's credit and financial standing. Many hospitals now ask obstetricians, especially, to provide lists of expected admission dates of OB patients, so the hospital has several months advance notice on these admissions. Under these conditions, it should be easy to obtain credit information and know exactly how the account should be handled at the time of admission.

Experience shows that one of the most vital aspects of the hospital's credit policy is to have advance information and, wherever possible, make payment arrangements before the patient is admitted.—E. W. JONES.

Housing Semiprivate Patients

Question: We are considering subdividing some of our wards into smaller, semiprivate units by installing movable partitions. One of our reasons is that we are crowded and have had to place many patients holding Blue Cross certificates in ward accommodations, whereas the certificate entitles them to semiprivate accommodations. This has been a troublesome problem. Can you give us information on the proportion of ward beds to semiprivate beds in the country as a whole? Is it common practice for Blue Cross members to be placed in ward accommodations when semiprivate rooms are filled at the time of admission? What is the usual price differential for ward and semiprivate accommodations? Finally, does "semiprivate" invariably indicate a room with two beds?—R.M.F., Pa.

ANSWER: This question was referred to an official of the Blue Cross Commission, who replied as follows: "In most of the country, semiprivate means a room with two to four beds. But on the East Coast, down to the Middle Atlantic area, it usually means two to eight beds, and we have heard of some hospitals with as many as 16 beds in a room that is referred to as semiprivate.

"Therefore, the only way to define semiprivate as far as Blue Cross is concerned is on a local basis, in accordance with local practice and understanding.

"We know of no national listing of the number of semiprivate and ward beds although some figures are available on a regional basis.

"Some Blue Cross members do have to accept ward accommodations because of unavailability of semiprivate facilities, but, in many instances, the Plan certificate provides that if the accommodations specified are not available, the member patient is entitled to the next *higher* accommodation."

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Who Handles Public Relations?

Question: Can a 100 bed hospital afford a full-time director of public relations?—J.B., Ill.

ANSWER: It is seldom done. In hospitals of less than 200 to 250 beds, the public relations program is generally the responsibility of the administrator, a member or committee of the board of trustees, a volunteer group such as the women's auxiliary, a part-time employe who may be connected with the local newspaper or radio station, or a member of the administrative staff who combines the public relations function with personnel, business office management, or another responsibility.

Maintenance Staff Needed

Question: How many employes should we require in the plant maintenance department of a 50 bed hospital?—H.B., Mo.

ANSWER: The average 50 bed hospital, according to a survey made by the U.S. Public Health Service, has three full-time employes in this department. This average or "prototype" hospital does not have a nursing school or residence. However, it is not possible to answer the question precisely without knowing more than simply the number of beds provided. Do you have a nursing school? Nurses' residence? Laundry? Power plant? Outpatient service? How extensive are the hospital grounds? Do you do your own painting, window washing, furniture repair, plumbing repair, or are these services contracted to outside agencies?

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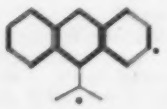
THORAZINE* ...*dramatic in emergencies*

vomiting
alcoholism
severe pain
hiccups
status asthmaticus



	Package Size	Price to Hospital
Ampuls 1 cc. 25 mg.	Boxes of 6 Packages of 100 **Packages of 500†**	$3.12 box 44.00 pkg. **195.00 pkg.**
Ampuls 2 cc. 50 mg.	Boxes of 6 Packages of 100 **Packages of 500†**	4.38 box 62.00 pkg. **240.00 pkg.**
Suppositories 25 mg.	Boxes of 6	1.23 box
Suppositories 100 mg.	Boxes of 6	1.53 box
Syrup 10 mg./5 cc.	4 fl. oz. bottles	1.53 each
Tablets 10 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	2.13 each 20.24 each **170.00 each**
Tablets 25 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	3.03 each 28.79 each **243.00 each**
Tablets 50 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	4.23 each 40.20 each **317.00 each**
Tablets 100 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	5.70 each 54.50 each **431.00 each**
Tablets 200 mg.	Bottles of 500 **Bottles of 5000†**	76.30 each **600.00 each**

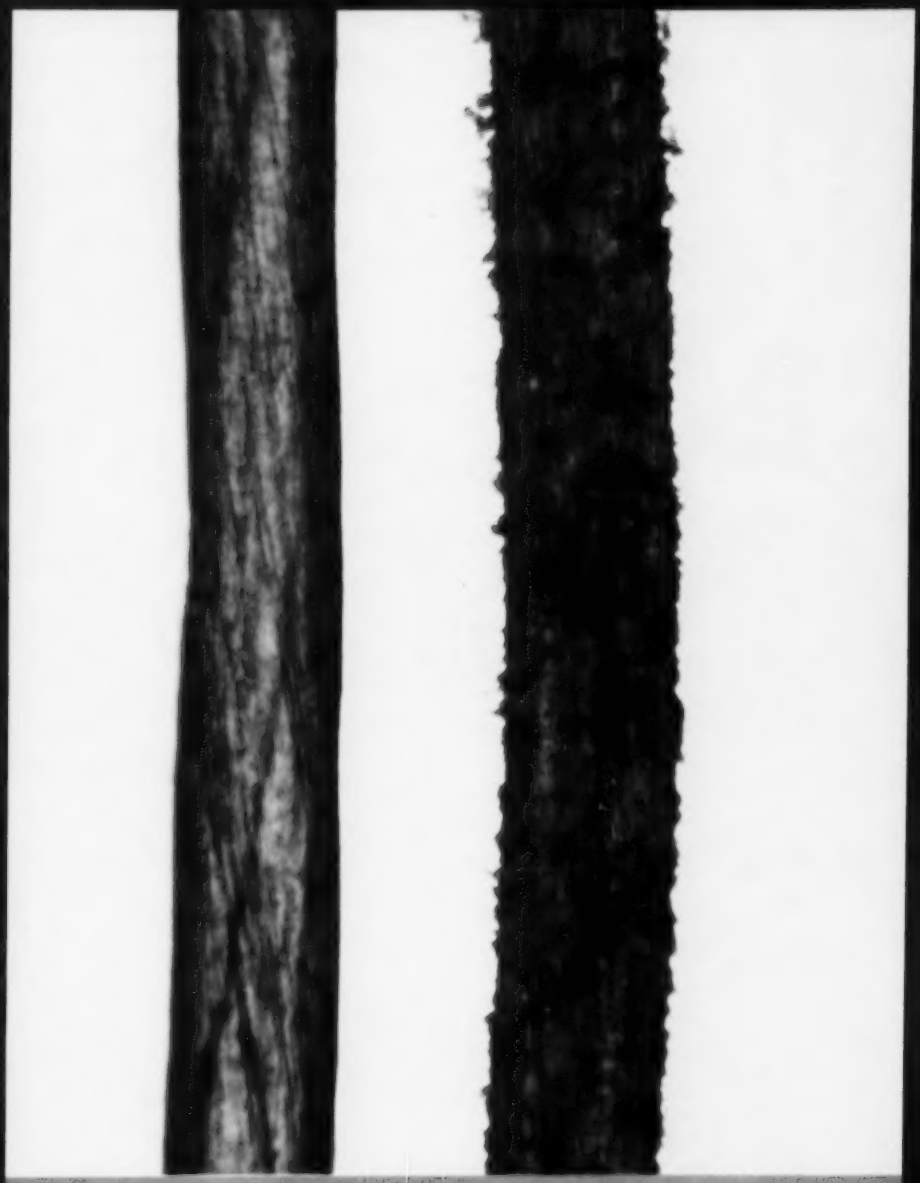
†Available only to *non-profit* (tax exempt) institutions for use within the institution.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

Research shows why D & G gut is stronger

PHOTOMICROGRAPHY SEES WHAT THE HAND CANNOT FEEL



D & G gut

Photomicrograph shows the smooth surface of D & G SURGICAL GUT, with practically no fraying or roughness. *Reason:* Carefully controlled slitting of plies plus uniform twisting provides a smooth, well-bonded strand. No need to grind it to size. Gentle polishing gave the matte finish. *Result:* the full natural strength of each gut ribbon (ply) is preserved; the strand is not frayed by grinding.

Another leading gut

Photomicrograph reveals rough, frayed surface of another leading brand of gut. This has been ground to size. Gut processed in this way appears very uniform in diameter to the naked eye. But the photomicroscope reveals serious imperfections which may cause fraying and loss of strength when the knot is tied.

see exhibit on next page

Photomicrographs (unretouched) by E. J. Thomas, Stamford Laboratory of the Research Division of the American Cyanamid Company, Stamford, Conn.

Method used: bright field, 138x. Material used: medium chromic gut, size 5-0.

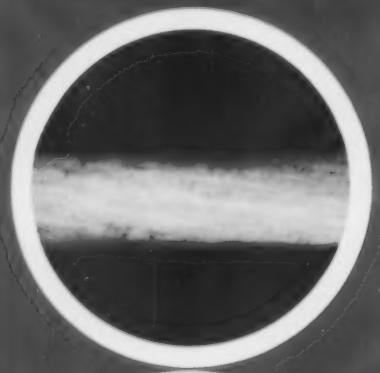
SUTURES AND OTHER D&G SURGICAL SPECIALTIES

DAVIS & GECK INC.

A UNIT OF AMERICAN Cyanamid COMPANY

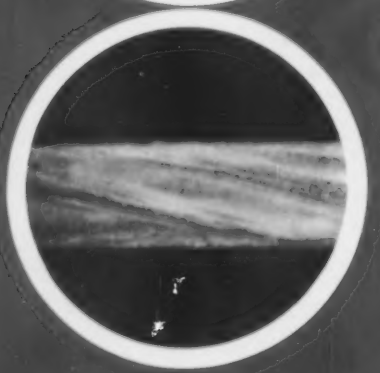
DANBURY, CONNECTICUT

Photomicrography shows why D & G gut is more flexible



D & G GUT

Firm, even cohesion of plies is apparent in this photomicrograph of a D & G SURGICAL GUT suture.
Reason: plies were twisted into a strand before suture was chromicized. Natural cohesive forces of moist untreated collagen firmly bond the plies together and hold the twist.
Result: under stress, plies of the suture hold together. The D & G gut is more flexible and knot strength is greater.



ANOTHER LEADING GUT

Photomicrograph detects separate and distinct plies in a strand of another leading brand of surgical gut. Here each ply was chromicized before they were twisted into suture strands. Such "ribbon chromicizing" hardens the surface of each ply, decreasing the natural bonding action, lowering the flexibility and tensile strength of the suture.

Photomicrographs (unretouched) by E. J. Thomas, Stamford Laboratory of the Research Division of the American Cyanamid Company, Stamford, Conn.

Method used: dark field, 38x.
Material used: medium chromic gut, size 00.

see exhibit on previous page

SUTURES AND OTHER D&G® SURGICAL SPECIALTIES

DAVIS & GECK INC

A UNIT OF AMERICAN Cyanamid COMPANY

DANBURY, CONNECTICUT

wire from Washington

PRESIDENT'S HEALTH PROGRAM

There is good news for hospitals in the Administration budget and in the Eisenhower health program. True, these items have to be passed on by a Democratic Congress, and in an election year—but the Democrats already are on record as promising as much or more than the White House.

In his messages to Congress, the President pointed out the value of a well rounded hospital program. He followed this up in his budget by asking Congress to vote a total of $130 million for the two Hill-Burton hospital construction operations. Here is the way the fund is broken down:

For the "regular" H-B program, $88,800,000, the same as the regular program had last year, but well above the figures for other recent years.

For the new program—grants for nursing homes, rehabilitation facilities, diagnostic-treatment centers, and chronic disease hospitals—$40 million, or almost double the $21 million available during the current fiscal year.

For research in hospital methods and technics—$1,200,000, or the same as this year.

There is not much to worry about from the Democrats. Senate Democratic Leader Lyndon Johnson, in a major policy speech that must have had the prior approval of other top men in the party, called for appropriation of the "full authorization" for the Hill-Burton programs. This would be about $200 million. So even if the Democrats don't hike up this item, there is not much chance they will want to cut it down.

The Administration also has shown liberal intentions in other fields where hospitals are involved:

A new program is proposed to pass out U.S. grants for construction of research facilities and to aid in the construction and equipment of medical, dental and other schools in the health field. For the first year, the White House is asking $40 million for these grants.

The Administration also wants Congress to provide federal insurance for mortgages on hospitals, clinics and other health institutions. This would be started off with a $10 million fund.

Other proposals in the President's Health Message:

1. **Appropriations** totaling $126,525,000 for research in cancer, heart and mental illness and other problems.

2. **Grants for programs** to help meet demands for additional personnel in medicine, nursing and related fields.

3. **Federal grants** to help states and communities care for the blind, disabled and dependent children. Health insurance for federal employes and improved medical care for servicemen's dependents.

"We must take further steps to improve the health of the people," President Eisenhower said, expressing a changed philosophy of government-in-health. "This further effort should be characteristically American partnership—a partnership in which private and governmental enterprise are joined to advance the national welfare. The important rôle of the federal government is to provide assistance without interference."

HEALTH INSURANCE

The President's health program proposals had a sharp reminder that Mr. Eisenhower and his people are not satisfied with progress in expanding coverage of health insurance. The President said the government is cooperating with private insurance companies to arrange for a reinsurance pool, but that if this can't be worked out perhaps Congress should take another look at the Eisenhower reinsurance plan that was turned down by the House two years ago.

Like the White House, a Senate subcommittee under the chairmanship of Senator Sparkman (D.-Ala.) is determined that something has to be done to extend insurance coverage and liberalize benefits. This group is centering its attention on the nation's low-income families, where it believes the greatest need exists.

V.A. TALKS BACK

Veterans Administration can't see much value in the Hoover Commission recommendations.

After studying the commission's suggestions for a year, V.A. gave its reply in a lengthy statement filed with the House veterans affairs committee. Most of the major recommendations were turned down flat. A few others were approved, but with the comment that V.A. already was accomplishing the same objective in another way.

V.A. said it saw some danger in a Federal Health Council if the council were given too much power: "It is of paramount importance that any such body should operate only in an advisory capacity, without any prerogative to direct action. . . ."

V.A. couldn't go along with the commission's plan to close certain specified hospitals, as that would be impossible unless Congress first changed the law to make fewer veterans eligible.

V.A. said the commission's idea to attempt to collect afterward for the care of a nonservice-connected case when the man was found to have financial resources was basically wrong, and that it also was inconsistent. The agency argued that it wouldn't make much sense to require an "in need" oath, then to try to collect; the oath would be evidence of indigency, so why try to collect?

V.A. replied to the commission that health insurance companies have rewritten their policies to exclude payment to any government agency, making it impossible to carry out the commission's suggestion of billing the companies.

CONFUSION AT LOS ANGELES WRECK SCENE CRITICIZED

Los Angeles.—Hospitalization and treatment of more than 100 persons injured in the Santa Fe railroad wreck the evening of January 22 was accomplished by hospital and private ambulance crews working independently, Dr. Kearney Sauer, assistant director of the Georgia Street Receiving Hospital, reported in an interview with The Modern Hospital.

Newspapers criticized police handling of crowds at the disaster scene. No one officer had full authority to act, it was charged; there was no disaster plan in effect to coordinate the efforts of various units; uncontrolled radio and television announcements drew throngs of curious sightseers to the scene, with resulting confusion.

"If the wreck had been worse and the number of injured doubled or tripled, it would have been several hours' labor to get those who were found late to the hospitals," said the *Los Angeles Times*.

Within seconds after the Georgia Street Hospital received word of the accident, which occurred within the city limits not far from the hospital, an ambulance was on the way to the scene, Dr. Sauer said.

Minutes later, two more ambulances were dispatched. The hospital operates a fleet of 15 ambulances, Dr. Sauer said, but the remaining 12 were not used on this occasion.

In addition to the Georgia Street Hospital ambulances, a large number of private ambulances were used to transport victims to hospitals. Altogether, upward of 50 ambulances were used, and some estimates placed the number at more than 100.

Failure to control ambulance and other traffic at the scene was one cause of confusion and delay, according to newspaper reports.

Georgia Street Hospital ambulances were equipped with two-way radio communication and staffed by trained attendants who helped railroad personnel, firemen, policemen and uninjured passengers remove the injured from wrecked cars. Attendants reported back to the hospital by radio. H. G. Robert, chief ambulance attendant, telephoned other hospitals regularly to find out how many patients each could conveniently handle, and ambulances were dispatched from the scene accordingly.

In addition to Georgia Street, where 31 patients were treated, hospitals receiving patients included Los Angeles County General, Queen of Angels, Rose Netta, Good Samaritan, Maywood, California, and the Santa Fe Coast Lines' own hospital.

All the injured requiring hospital treatment were on the way to hospitals within 40 minutes after the accident was first reported, Dr. Sauer said.

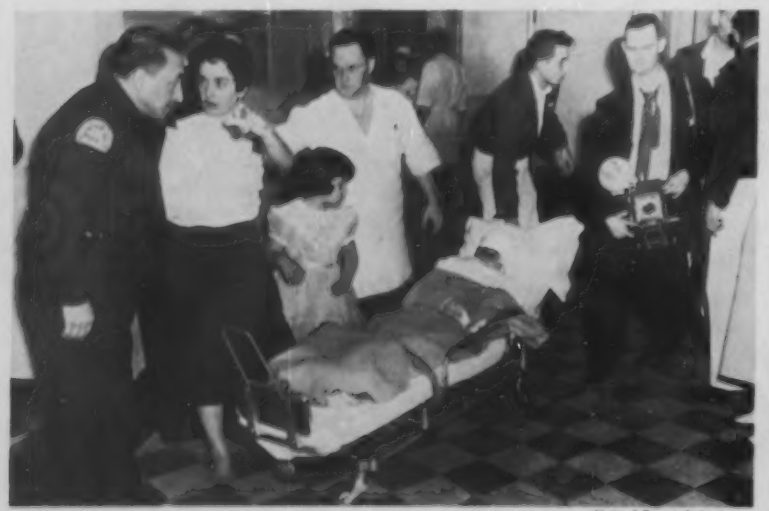
Hearing radio and television announcements, some doctors and nurses went directly to the scene, it was reported. For the most part, however, only first aid was administered there.

"Doctors, nurses, soldiers, clergymen and first-come representatives of the disaster relief organizations milled around in anxious futility," said a newspaper account.

Early radio and television reports were described as "exaggerated and hysterical."

"Broadcasting them served the useful purpose of bringing doctors, nurses and ambulances to the scene in platoons," the *Times* said in an editorial, "but the broadcasters counterbalanced their usefulness by setting all the sightseers on the highways on their way to the wreck scene, and nobody had the wit to stop them."

There was no criticism of the way Georgia Street or other hospitals handled accident victims, and a reporter praised the switchboard at Georgia Street for intelligent handling of the flood of inquiries that poured into the hospital.



United Press Telephoto.

An unidentified mother talks to ambulance driver (left) as her son is being removed from Georgia Street Hospital to a private institution.

United Press Telephoto.

Ambulance driver helps fireman remove one of the victims of wreck.

The Modern Hospital
FEBRUARY 1956

LOOKING AROUND

Whose Loss?

HOSPITAL people everywhere are understandably concerned about the district court decision in Iowa holding that hospitals employing physicians on salary and percentage arrangements are engaged in the illegal practice of medicine. The Iowa Hospital Association is appealing the decision to the state supreme court, and association attorneys have advised that hospital arrangements with specialists need not be revised while the case is under appeal.

Meanwhile, hospitals in Iowa and a number of other states having medical practice acts with similar provisions governing the practice of medicine by corporations are face to face with the possibility that the Iowa decision may stand on appeal, making it illegal in Iowa, and hazardous elsewhere, for hospitals to do anything more than maintain laboratory and x-ray facilities, as they do operating rooms, for use by doctors in the community who can qualify as staff members.

Under such an arrangement, presumably, the hospital might charge its patients a modest "use of facilities" fee, comparable to the operating room charge, while pathologists and radiologists using these departments would be on their own, competing with one another for patients. Inevitably, since the average patient doesn't know a pathologist from a paratrooper, the selection would be made by the clinician, instead of the patient. Depending on the clinician's favors for his livelihood, the pathologist or radiologist might easily be inclined to temper his scientific judgment with a businessman's eye for future sales. The value of these specialists as an educational force and guardian of medical quality in the hospital would plainly be diminished, if not destroyed, under these circumstances.

Is this what Iowa pathologists wanted? We doubt it. Queried shortly after the district court decision was handed down, one of the principals on the medical side of the Iowa litigation acknowledged that he had not foreseen such a sweeping victory and was not sure where the pathologists and radiologists should go from here.

We have a suggestion. Let one hospital in, say, Des Moines anticipate a supreme court decision upholding the district court and switch immediately to an "open staff" arrangement in pathology and radiology—letting the chips, and the fees, fall where they may and letting the pathologists and radiologists scramble for business as other doctors do. Then let one small hospital turn its technicians, who are practicing medicine, according to the district court ruling, over to the supervision of remote specialists who would become responsible for the entire operation—including, of course, any errors or negligence on the part of the technicians. Let the specialists run these departments at arm's length, sending their bills to patients who never heard of them, and see how they like it.

A few months of operation on this basis, we are convinced, would have everybody screaming murder—including District Judge C. Edwin Moore. The pathologists and radiologists would scream loudest of all, we suggest. Their associates on the attending staffs who helped them get the court decision would be only a little less confused and unhappy. As their doctors' bills mounted in the mail, patients would join the chorus.

The hospitals would be hurt least of all. Actually, they could expect to have fewer management headaches. But they would have to abandon a measurable fraction of the ideal of serving and protecting their patients as hospital patients want to be served and need to be protected.

Let's Catch Up

LAST month, the Veterans Administration had heartening news for all who are interested in the welfare of the mentally ill. The V.A. announced a nationwide program of opening closed wards and transferring long-term psychiatric patients to open ward status in general medical and surgical hospitals. The program will provide more intensive treatment and rehabilitation for these patients, many of whom have been in closed wards in neuropsychiatric hospitals for months, or even years, the V.A. said. Experimental programs have proved many of these patients can be reconditioned for freedom and independence in the hospital and in the community, it was explained.

If the V.A. "push" to open its closed wards is successful, it may encourage state, voluntary and proprietary psychiatric hospitals to do likewise, and, more importantly, it may encourage general hospitals to accept psychiatric patients —a badly needed development that has been widely discussed, but not

vigorously pursued, in recent years. Unlike the V.A., most voluntary hospitals are still fighting shy of patients with mental or emotional disturbances. In its forthcoming study and evaluation of the problems of mental illness, the newly organized Commission on Mental Illness, of which the American Hospital Association is a sponsoring agency, should devote a part of its efforts to determining why the medical profession and hospitals can't catch up with the general public, at least, in their attitudes toward mental illness and mental patients.

Dangerous Assignment

UNDER a mandate from the House of Delegates, a continuing Committee on Medical Practice of the American Medical Association is going to conduct a study of the relative value of diagnostic, medical and surgical services, as recommended by the original Committee on Medical Practice, or Truman Committee, a few months ago. Furthermore, the new committee is charged with developing a program of public education "designed to bring about a better understanding of all fields of medical practice." The context of this recommendation made it clear that the public education program was to be aimed at upgrading nonsurgical services in the public mind.

These are interesting, if not dangerous, assignments. How many house calls equal a cholecystectomy? Should a truck driver who recovers from tuberculosis pay his doctor more, or less, than an insurance salesman who recovers from appendicitis? If a fracture of the femur costs three blue chips, how many red chips should we pay for a chest x-ray?

Actually, there is nothing new about relative value scales in medicine. Every Blue Shield fee schedule, every insurance contract, every workmen's compensation board has its relative value scale. The astonishing thing is to find the American Medical Association, which has always resisted the concept that medical services can or should be evaluated on a dollar yardstick, not only accepting but encouraging the development of a system which is going to look like a move in the direction of standardized fees, whatever the units may be called.

If the committee does its assigned job thoroughly and comes up with a relative value system, we don't think the doctors are going to like what they ordered. And the better the committee carries out its assignment of public education, the less comfortable will be that occupationally uneasy group, the A.M.A.'s lawyers, who fidget nervously whenever anybody says "trade," or "trust," or "price."

Apparently, nobody was listening last December when A.M.A. President Elmer Hess addressed the House of Delegates: "Doctors take care of sick folks, period," he said.

Satisfied?

WE'VE been puzzling and puzzling over a bulletin from the American Medical Association reporting the results of a public opinion poll in the Los Angeles area. Like a man whose wife is a secret drinker, doctors in Los Angeles, apparently, were worried about what the neighbors were thinking, so they hired a professional nose-counter to find out what people think of doctors.

On the whole, it turned out, the neighbors were pleased, but one paragraph in the A.M.A. bulletin about the Los Angeles survey has kept us awake nights: "Eighty-eight per cent of those interviewed were satisfied with physicians' fees, but 30 per cent were of the opinion that medical fees generally were unreasonable," this said.

If this means anything at all it must mean that 18 per cent are satisfied with unreasonable fees. Anyway, doctors might as well stop worrying about what the neighbors think. Nobody knows—including the neighbors.

Virtue for Sale

A HOSPITAL conducting a fund raising campaign recently passed the word along to employes that they would be expected to "contribute" three days' pay over the three-year period of the campaign. Contributions will be deducted from pay, and the front office has indicated it expects all loyal employes will sign the pledge right away.

"You get the idea pretty fast," a department head told us, "that employes who aren't considered 'loyal' are not likely to last as employes."

Now it can be argued—and trustees of the hospital have unquestionably argued themselves into believing—that anybody can afford to give one day's pay a year and that hospital employes, especially, should believe in the hospital enough to contribute to its fund raising campaign.

But the fact is that in this hospital, as in many others, some employes are still paid minimum wages—far less than the prevailing rate for hourly paid personnel in the community's industries—and, much as they might like to help, these people need every day's pay they get, and then some.

Moreover, the subtle pressure of a suggestion by management that "loyal" employes will want to contribute is inconsistent with the high ideals of voluntary service that are supposed to be characteristic of our hospitals. Like city hall payrollers who are "invited" to contribute to the war chest of the political party in power, hospital employes feel that contributions to such a campaign are actually compulsory, and they resent it.

This is a big hospital, with a budget that probably exceeds $2 million annually. In three years, the day's-pay-a-year tax will yield only about $20,000 —an appreciable amount even in a campaign for millions, perhaps, but still too low a price at which to sell the hospital's voluntary virtue.

Surplus

IT IS hard to surprise an experienced hand in a business where the unexpected is routine and the impossible happens right along, but Administrator Robert Jones of Waukesha Memorial Hospital, Waukesha, Wis., was startled one day last month to learn that a patient in the hospital was attempting to pull a unique switch on the hidden baby trick. The patient had registered under the name of another woman, it turned out, and was planning to have her baby officially registered as the other woman's child when it was born. Childless, the other woman had offered $300, plus hospital expenses, for the baby, it was reported. The hoax was revealed when a physician discovered the name switch. Obviously baffled, the district attorney decided not to prosecute the mother, who has seven other children.

What would you do in case of

OPERATING ROOM EXPLOSION?

From 80 to 100 times a year an anesthetic explosion occurs in a U.S. operating room. Here is a report of how one hospital handled such an episode

JANE BARTON

Mrs. Doke Dies After Surgery

JAN. 20.—Mrs. Howard B. Doke, 57, of 5319 Dale Ave., wife of Professor Howard B. Doke of the University of Wisconsin drawing and descriptive geometry department, died Wednesday in a local hospital following surgery. Mrs. Doke was active in Red Cross and Civil Defense work.

Mrs. Walter J. Kohler, chairman of Red Cross service groups, paid tribute to Mrs. Doke's community service today, saying: "We saw her last Thursday and were prepared to have her return to service after a month of convalescence. I was shocked and sorry. . . ."

THE only thing wrong with this story which appeared in the Madison, Wis., *Capital-Times* Jan. 20, 1955, was what it did not say. While, technically, it could be said that Mrs. Doke died following surgery, actually she died in spite of surgery performed in a fruitless effort to save her life following an anesthetic gas explosion. And the shock and regret expressed by Mrs. Kohler, profound as they undoubtedly were, were nothing at all to the shock and regret felt by officials of the University of Wisconsin Hospitals, charged with the difficult duty of explaining to Mrs. Doke's family and the public what had happened—and why.

The *Capital-Times* reporter didn't get his facts wrong; he reported precisely what had been told him when he made a routine call to the hospital to check on persons who had died during the day. It is standing policy at the University of Wisconsin Hospitals to give reporters (who call twice a day) the names and addresses of deceased patients; the cause of death and the name of the attending physician are not given. Except in unusual circumstances, the papers do not even name the hospital.

In the case of Mrs. Doke, Dr. Harold M. Coon, superintendent of the hospitals, saw no reason to deviate from this policy. In fact, he saw every reason not to. He believed, and still believes, that until the cause of the explosion had been determined, publicity could have resulted only in frightening patients in all Madison hospitals who were about to undergo surgery—without serving any useful purpose. "It was not a question of protecting the hospital or myself," Dr. Coon said later. "Enough patients and patients' families were concerned so that they should be protected from undue worries."

The next day, however, one of the Madison papers called in considerable perturbation to inquire the exact cause of Mrs. Doke's death. Some alarming stories were being circulated around town, *i.e.* that one of the operating rooms had been blown up; that *all* the operating rooms had been rendered useless, and so on. Wouldn't it be a good idea for the hospital to reveal the facts? Dr. Coon didn't think so. He explained what had happened to an official of the corporation that owns both Madison papers and requested that further comment be withheld until the hospital was ready to call a press conference. This was set for Monday, January 24, after Mrs. Doke's funeral and after the hospital had completed its investigation. Somewhat reluctantly, the city editors of the *Capital-Times* and the *Wisconsin State Journal* agreed that perhaps he was right. The fact that the papers acceded, even reluctantly, was, in Dr. Coon's opinion, a measure of their confidence in the hospital. And there, insofar as publicity was concerned, the matter rested as of Friday, January 21.

STORY BROKE ELSEWHERE

On Friday afternoon, feeling that the situation was in hand, Dr. Coon left for Des Moines, Iowa, and Dr. O. S. Orth, chief of the anesthesia department, also left for an anesthesiology meeting in North Carolina. Early Saturday morning, Dr. Coon was called in Des Moines by Dr. William S. Middleton, dean of the university's school of medicine, who reported that "all hades has broken loose." The reason: Although the Madison newspapers had kept their promise not to reveal the cause of Mrs. Doke's death until the hospital officials

had released it, the story got out anyway and had broken in a paper in another city.

In its Sunday edition, the paper there took out in full cry, with acid references to the fact that "the accident happened Wednesday but was not reported to the public until Saturday. University officials had persuaded Madison newspapers not to tell the cause of Mrs. Doke's death for a week or ten days." The Dane County coroner, Stanley C. Larsen, according to the story, was outraged and threatening an investigation because his office had not been notified of the accident until two days after it had happened. The law says the coroner must be informed of all accidental deaths within 24 hours.

Dr. Coon came home right away. First he called Dr. Orth and told him of the furor. He asked Dr. Orth to request Dr. George Thomas of the University of Pittsburgh, widely known for his researches into the causes and cures of anesthetic explosions, to come to Madison and conduct an investigation.

Since the story had already appeared elsewhere, the Madison papers no longer felt bound to observe their commitment to the hospital and, on January 22, the *Capital-Times*, an evening paper, followed up the first story with one that was headlined: "Hospital Reveals Cause; Coroner to Probe Mrs. Doke's Death."

HOSPITAL ISSUES STATEMENT

The story was also picked up by the wire services and the Chicago papers, and at this point the hospital issued a formal statement explaining its reasons for withholding the announcement and pointing out that the results of Dr. Thomas' and the hospital's own investigations would be made public when all the facts had been gathered. The press conference scheduled for Monday was deferred until Wednesday, January 26.

What were the facts? What circumstances combined to cause an explosion in a hospital in which there had been no fatal anesthetic gas explosions before and in which many of the safety devices used by hospitals all over the country had had their initial tests? Thus, it was peculiarly embarrassing, Dr. Coon reflected ruefully to a reporter, that the accident had to happen in the University Hospitals. The explosive mixture was ether and oxygen and just why it elected to explode at that moment will probably never be satisfactorily explained.

The sequence of events, as related by Dr. Coon, was as follows:

While the surgeon was scrubbing up, Mrs. Doke was being anesthetized. A supervising anesthetist, a resident anesthetist, a nurse and an orderly were in the room. The resident induced the anesthesia with cyclopropane for four minutes; however, the cyclopropane had been stopped for six minutes before the explosion occurred and had all been dissipated. [The innocence of the cyclopropane was confirmed in Dr. Thomas' report.]

Following the cyclopropane, ether was started by flow of O_2 through a copper ether vaporizer on a new type of anesthesia machine. While the patient was being anesthetized, the orderly strapped her left wrist in the wristlet attached to the operating table and the supervising anesthetist strapped the right one. The orderly who was standing at the left of the table then reached across the patient's body to adjust the screen for draping and, in so doing, passed his hand through the ether-oxygen vapor.

Whether he actually brushed the face mask or not no one knew. The next thing anyone did know was that there was a roar and a sheet of orange flame about 12 inches above the mask. The supervising anesthetist found herself half on the floor, stunned and feeling that she had been permanently deafened. She wasn't. Nor was anyone else in the room injured. The anesthesia machine and all other equipment, and the room itself, remained intact. With the freakishness that characterizes such explosions, it damaged nothing but the patient.

As soon as she realized what had happened, the supervising anesthetist stopped the flow of O_2 to prevent a fire. The surgeon, emerging from the scrub room at the moment of the blast, concentrated all his energies on trying to save Mrs. Doke, who was still alive. In spite of his efforts, which included two operations on the chest to suture rents in the trachea and the left main bronchus, she died four hours later of "anoxia because of extensive damage to the alveoli."

Although it may have sounded like the end of the world to the personnel in Operating Room 3, the explosion created little disturbance throughout the rest of the hospital and operations that were going on in other surgeries near by were not disrupted. Dr. Coon, in his office on the first floor, was unaware of the accident until he was notified by the operating room supervisor.

As soon as he had been apprised of the situation, Dr. Coon took upon himself the task of telling Mr. Doke what had occurred and what was being done for Mrs. Doke. In this he was assisted by the chief of the anesthesia service and by Mrs. Doke's surgeon, in the moments he was able to spare from his patient. "I had not known Mr. Doke previously," Dr. Coon said, "but I came to know him very well indeed in the course of that day."

That day and the ensuing ones were strenuous. The university authorities were promptly informed and an investigation of the cause of the accident was started. The headline in the *Capital-Times* for January 24 read: "Devices Had Been Checked; Experts Probing Surgery Blast."

ALL DEVICES WORKING

In their probing, the experts determined that all mechanical devices were in proper working order. They had, in fact, been checked routinely a couple of weeks previously. But, said Dr. Coon, "All the mechanical devices in the world aren't worth anything unless there's a brain cell working. You can't do a routine anesthesia. You have to think." The next problem, then, was to determine whether somebody's brain cells had stopped functioning long enough to permit the accident to happen. As far as could be determined, no one's had. A step-by-step check of what each person involved had done prior to the explosion showed nothing out of the ordinary.

However, the humidity reading in the room on that morning was 23 per cent, Dr. Coon stated. The recommendation in a pamphlet issued by the safety engineering department of a leading insurance company is that "humidity should be kept at a minimum of 65 per cent at all times to reduce the possibility of electrostatic spark discharges." In the opinion of Dr. Thomas, the humidity should be maintained between 50 and 55 per cent the year round, and the temperature should range between 72 and 78° F. Dr. Thomas also recommends that all operating rooms be equipped with recording devices to show hourly humidity and temperature conditions in anesthetizing locations.

"The low humidity was not a cardinal factor in setting up the explosion," Dr. Coon stated. He added that the operating room staff is trained to watch the humidity and take proper measures against static electricity, particularly in the early morning when the room has not been in use for several hours. As the day goes on, Dr. Coon explained, the humidity rises. The atmosphere is driest early in the morning and Mrs. Doke's operation had been one of the first ones scheduled.

The usual precaution of using wet towels to increase humidity had been observed and, since all members of the operating room staff had also grounded themselves according to regulations, Dr. Coon and his associates are still baffled as to how the static charge could have been built up. In his report on the anesthesia equipment, Dr. Thomas said that by brushing his hand lightly over the rubber face mask he was able to build up 500 volts of electricity. "But nobody stands around an operating room brushing his hands over the equipment—so that couldn't have been it," Dr. Coon commented.

ORIGIN OF SPARK UNSOLVED

As so often happens, the experts disagreed on some things. A university physicist inclined to the belief that the spark had been struck when the metal tubing of the screen was slipped into its metal socket on the operating table. But Dr. Thomas' report discounted that possibility. Again, Dr. Thomas suggested that perhaps the orderly whose hand apparently set off the charge had not been grounded. But that was answered by the supervising anesthetist's report that both she and the orderly had automatically grounded themselves when they strapped Mrs. Doke's wrists to the table. So the question: "Who or what struck the spark?" remains unanswered.

Almost a year after the accident, a well meant but fatuous observation by a reporter to the effect that the explosion seemed to have been "just one of those things" set off another explosion—this one in Dr. Coon's sense of the fitness of things. "Remarks like 'It's just one of those things' set me crazy," he snapped. "It shouldn't have happened. We do everything we can—sure—but the fact remains the woman is dead, and that's not good. You can't just dismiss it like that."

On January 26 the deferred press conference was held. The *Capital-Times* reported the meeting the next day under the headline "Experts Report on Investigation: Static Blast of Ether-Oxygen Caused Death of Mrs. Doke." The story read, in part, as follows:

"The explosion of anesthetic gas which resulted in the death of Mrs. Howard Doke at the University Hospitals a week ago was caused by the ignition of a mixture of ether and oxygen gas commonly used as an anesthetic, experts stated at a conference at the hospital.

"The conference for newsmen and other interested parties was called by Dr. H. M. Coon, superintendent of the hospitals, for an explanation by experts of the investigation into the death of the wife of an assistant professor of drawing and descriptive geometry at the University of Wisconsin. Dr. George Thomas of the University of Pittsburgh, who has been conducting research into explosions of anesthetic gases since 1938, and Dr. John Gilroy, Madison, safety engineer and director of research at the Ohio Chemical and Surgical Equipment Company, agreed from their investigation that the explosion was in a mixture of ether and oxygen anesthesia gas and not in a mixture of cyclopropane and oxygen, as originally believed.

"Dr. Sidney Orth, head of the anesthesia department, said that the electrostatic discharge ignited the ether-oxygen mixture in the rubber bag of the anesthetic device and that the detonation went through the mask into Mrs. Doke's trachea, bronchial tubes and lungs. . . .

80 TO 100 EXPLOSIONS A YEAR

"Dr. Thomas said that in spite of all the precautions taken in construction of hospitals, surgical equipment and in surgical procedures, there are from 80 to 100 explosions of anesthetic gases from electrostatic discharges annually throughout the nation. Hospitals and manufacturers are working constantly to devise equipment and procedures to reduce these hazards, Dr. Thomas said. . . .

"Dr. Coon explained that the explosion as the cause of Mrs. Doke's death was not published through cooperation of the Madison newspapers immediately after the death because the hospital staff did not wish to cause 'distress' among patients awaiting surgery in local hospitals. He said that the information was withheld pending an investigation and that Wednesday's conference, which included questions and answers by those attending, was for the purpose of explaining the circumstances. 'The newspapers,' Dr. Coon said, 'have demonstrated a fine concept of the relations between patients and physicians.'

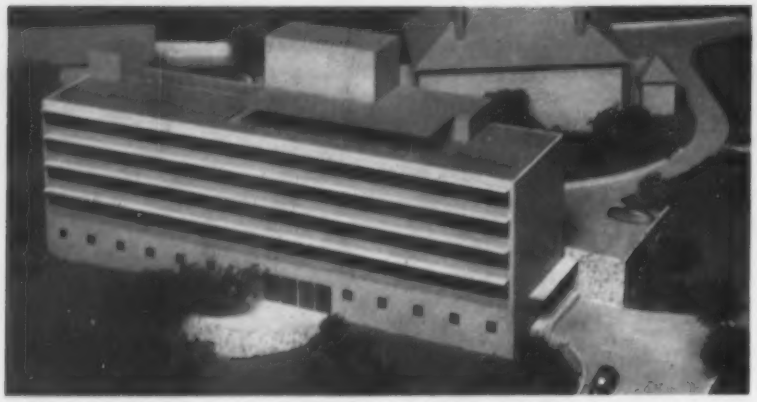
"Coroner Larsen has ruled the death an accident and has determined there will be no inquest. . . ."

Throughout all of the proceedings, Dr. Coon reported, Mrs. Doke's husband and sons had displayed remarkable forbearance and understanding of the situation. They brought no charges of negligence or malpractice against the hospital or any individual. The only question raised was whether a nonprofessional person [the orderly] should have been permitted in the operating room. However, they accepted the hospital's assurance that the orderly's presence was routine procedure and that he had been adequately trained to perform his duties.

STATE VOTES COMPENSATION

In conference with hospital officials, the family's attorney urged that some compensation was owed Mr. Doke "for the loss sustained and expenses incurred by him" in consequence of his wife's death. Since the University Hospitals are state owned they cannot carry insurance against such claims because the state is self-insured. Furthermore, one cannot sue the state without its permission. At the attorney's behest a resolution was introduced in the state legislature by an assemblyman asking permission for the family to sue. Compensation asked was $5000. The bill, introduced on Feb. 18, 1955, was first referred to committee and later sent to the state claims commission for hearings. Hearings were held July 19, 1955, and on November 26, the final headline in the Doke case appeared in the *Capital-Times*: "Local Death Blast Measure Signed." The story read: "A bill appropriating $5000 to Prof. Howard B. Doke, 5319 Dale Ave., for the death of his wife as a result of an operating room explosion at University Hospitals was signed by Gov. Kohler Friday. Mrs. Doke, wife of the University of Wisconsin professor, died last January 19 after an anesthetic explosion."

In transmitting a copy of the act passed by the legislature to THE MODERN HOSPITAL on December 12, Dr. Coon wrote: "The enclosed, I think, is the end of our story on anesthesia. Now it can be written up."



THE MODERN HOSPITAL OF THE MONTH

Model of Litchfield County Hospital, Winsted, Conn. Staff dining room terrace indicates ground level. Service parking is indicated in the lower right corner; ambulance parking is above.

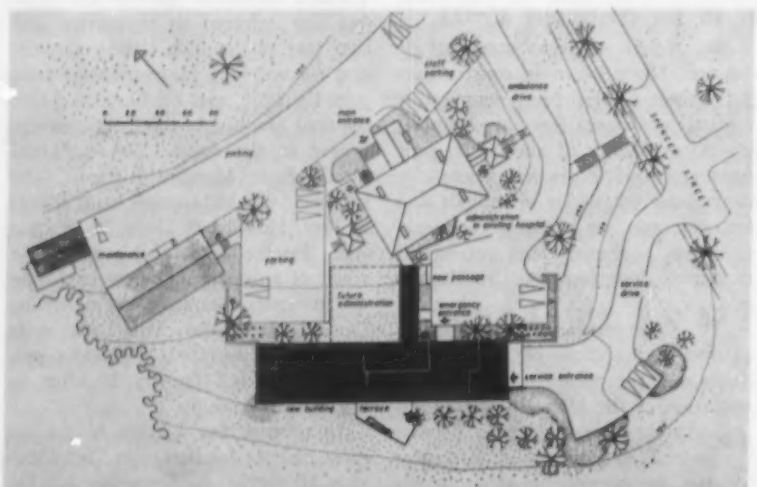
Prestressing Takes a Strain Off the Budget

and makes the best use of both steel and concrete

ELIZABETH K. SMITH

THE site chosen for this hospital was a difficult one with a very steep hill separating it from the existing building. Inasmuch as adequate parking space was needed, a multi-storied building was indicated for the site. It was decided to use an elongated, rectangular shape which would go parallel with the slope and allow easy access to the old main building. It was decided to lift the concrete slabs and to prestress them rather than pour them in place as is conventionally done. This was for reasons of economy and to reduce the number of interior columns. The lift-slab technic is best explained by the drawings. Prestressing places the steel reinforcing of the slab in tension before the slab is lifted, thus getting the greatest possible efficiency out of both steel and concrete and enabling the slab thickness to be reduced. The outside of the building is a skin rather than a supporting wall. It is hung from the edge of the slabs.

Mrs. Smith is public relations counsel for Sherwood, Mills and Smith, architects, Stamford, Conn.



Site plan of the hospital shows the location of the old building in relation to the new one which will be connected by a corridor.

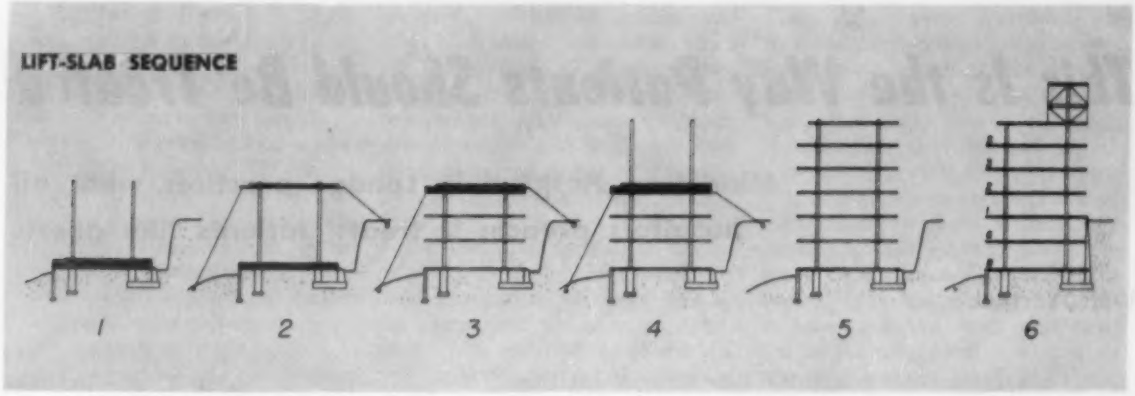
The lowest level contains the housekeeping and service elements, including the kitchen, staff dining room, boiler room, and morgue. The staff dining room faces on the south side of the slope and has its own terrace which makes it pleasant and sunny.

Next level is the ambulance and emergency unit, including diagnostic and medical service, x-ray, radiology, laboratory, emergency and two operating rooms; also central sterile supply and sterile corridor leading to the operating section.

Maternity section is on the ground floor. This floor goes directly to the old building on the ground level. It contains delivery room, patient rooms, emergency delivery room, and is directly above the operating floors below.

The second floor includes medical and pediatrics units and the third includes medical-surgical patients. There are no wards. All rooms can be either single or double with bathrooms in between each pair.

The top floor will eventually be a solarium, but at the moment this will be eliminated from the early building program.



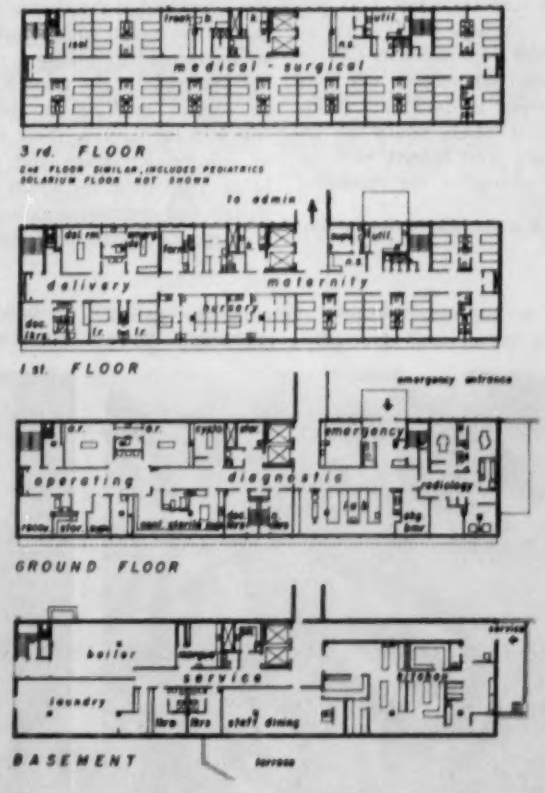
This diagram illustrates the sequence of operations used in lifting the prestressed reinforced concrete slabs into position by means of hydraulic jacks. Figure 1 shows the slabs poured one on top of the other with parting compound between, columns in place, ready for lifting. In Figure 2 the two upper slabs have been lifted to a temporary position and guyed. Figure 3 shows the three bottom floor slabs in final position. In Figure 4 the columns have been extended to their full height, and in Figure 5 all the slabs are in final position and the guys are no longer needed as the structure is now rigid. The elevator penthouse and uphill retaining walls are then added as shown in Figure 6. The lifting of the slabs in two successive operations is made necessary by the extreme height of the columns, this being the ***highest prestressed lift-slab operation so far attempted in this country.*** The system was selected because of economy for this type of multistory building.

OUTLINE OF CONSTRUCTION COSTS

Total project cost		**$1,188,600**
Number of beds	**87**	
Cost per bed		**$12,512.13**
Number of square feet	**46,878**	
Square feet per bed	**583**	
Cost per square foot		**23.22**
Number of cubic feet	**542,313**	
Cubic feet per bed	**6,233**	
Cost per cubic foot		**2.01**

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

FLOOR PLANS The service units are on the lowest level, as is the staff dining room which faces on a pleasant terrace. The hospital's top floor will eventually be a solarium



This Is the Way Patients Should Be Treated

Middlesex Hospital in London practices what all hospitals preach: It treats patients like guests

WENDY HALL

"THE patient must always be treated as a guest of the hospital." Thus Brigadier G. P. Hardy-Roberts, secretary-superintendent of the Middlesex, one of London's great teaching hospitals, defines the attitude of the medical and administrative staff toward their patients. The words are neither a vague expression of good will, nor a slogan developed with a technic. They are a precise summary of a whole philosophy of hospital medicine, passed from consultants to housemen, students and nurses over the course of many years, fully shared by the administrative staff, and both consciously and unconsciously put into practice.

They also sum up what most patients want from a hospital, as far as can be gathered from unofficial surveys and interpreted comments. For that reason, this article is based on the Middlesex Hospital which, though by no means the only great hospital with an outstanding reputation for successful patient relationships, typifies the standards which the medical profession and the lay public would wish to see adopted and adapted, within their various limits, by all types of hospitals.

Consider this attitude in terms of the good private hostess. She comes to the door herself to welcome the guest; she has arranged the flowers in advance, prepared a meal or a drink; as well as making the bed, she has put reading matter in the guest room.

It is a matter of course that the new patient arriving at the Middlesex should be welcomed in the same way, and perhaps with a little extra care, because the house guest arrives happily, the patient, nervously or fearfully. He is received in the spacious, paneled hall, whose murals and beautiful flower arrangements barely suggest a hospital, not betrayed by the faintest smell of chloroform or drugs. If there are a few minutes to wait, there are plenty of comfortable seats, and a trolley brings the cup of tea which people in Britain find essential in times of strain.

In most hospitals, inpatients are admitted by a lay receptionist. The Middlesex is an exception. It sets great store by the fact that all inpatients are checked in by a senior sister in uniform. There has been much comment recently in Britain on the alleged wastage of trained nurses on administrative duties, but the Middlesex is convinced of the enormous value of reception by a sister. Why? Because most new patients, and their relatives, arrive with something on their minds. They may be only trivial questions, but how much it helps if they can be answered immediately by someone who really knows. To many of them, a lay receptionist would be obliged to say: "You'll have to ask the sister," and so might make the patient feel that he had fallen into one of those nightmare mazes where questions can be answered only by the next-but-one person.

The routine side of admission is quickly dealt with. The sister takes down all necessary personal details on a machine which makes five copies. These go to the ward, the records department, the almoner, the resident

Miss Hall is a magazine writer in London, England.

On arrival at Middlesex Hospital, London, the patient is met by a porter and directed to the proper clinic.

At Middlesex Hospital, inpatients are checked in by a senior sister who records all details on a machine.

medical officer, and the chaplain of the patient's denomination. There is a resident Church of England chaplain, but Catholic, Nonconformist and Jewish patients are visited by their own chaplains who are notified as soon as the patient arrives in hospital. The sister then asks the patient which newspapers he wishes to have delivered to his bed. The order goes through to the news agent automatically, and the patient realizes that he is not just a case, but a person whose preferences, spiritual and mental, are respected.

From the main hall, the patient goes to the x-ray diagnostic department, where his chest is examined by mass x-ray apparatus, and is then escorted by the porter, who carries his luggage, to the ward, where the ward sister is waiting to welcome him. There is never any long and anxious period between crossing the hospital threshold and reaching the bed. In fact, one patient reported to the secretary-superintendent to this effect: "I was undressed and in bed within 20 minutes of arriving in the hospital. Is this a record?"

"Patients," says the secretary-superintendent, in the book he has written specially for the hospital administrative staff, "have a right to expect efficiency and kindness from everyone." These two qualities are evident not only in methods of admission. There is a long tradition of kindness and courtesy at the Middlesex, and the tradition has been zealously upheld and cultivated. It begins with the senior staff, with the consultants who are not too aloof to have a friendly word with patients other than their own; it is seen in the extra good manners displayed by medical and other staff among themselves, which add immeasurably to the general harmony of the hospital; it filters, by precept and practice, down to the porter who directs patients at the entrance, and is considered to play an important part in the hospital-patient relationship.

The effect on the patient can be gauged by the action of the excessively difficult outpatient who came back to the receptionist to apologize: "I'm sorry I was so tiresome. When you went on smiling instead of telling me off, I knew I was wrong." Or, to put it another way, the tense, nervous patient had been relaxed by courtesy.

INFORMATION IS PROVIDED

Midway between kindness and efficiency, which cannot exist without each other in a hospital, one might include information, which partakes of both. Just as the host regards it as elementary politeness to tell the guest the times that meals are served and the way round the house, so the Middlesex thinks it important to tell the patient all that he needs to know about the hospital. When the day of admittance is decided, he is sent leaflets which tell him what to bring with him, visiting hours and so on.

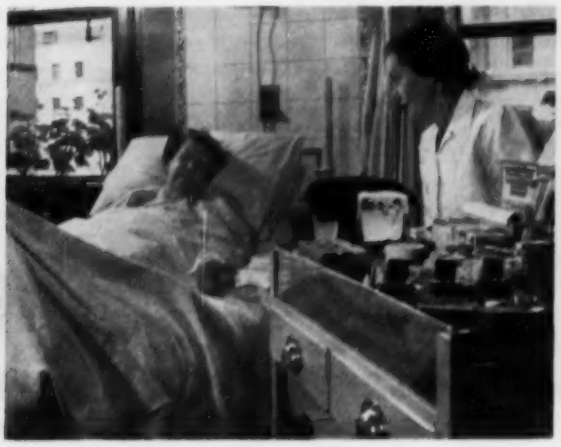
On arrival, he is given a booklet which tells him, in simple and friendly language, of all the arrangements made for his benefit by the hospital, and includes such useful hints as how to distinguish staff and students by their coats and overalls. It adds, with a humility rarely shown by a great organization to a single individual, that things do go wrong sometimes, and that the secretary-superintendent will welcome any suggestions for improvement from patients when he visits the wards each week.

Information about the patient's illness presents a more difficult problem. One of the commonest complaints of patients and relatives is that they cannot find out anything about the course of the illness. The problem is twofold: how much a patient ought to know, and how much time medical and nursing staff can give to answering inquiries. At the Middlesex, the medical staff gives patients themselves the fullest information as long as there is no reason for withholding it, and the house officer and ward sister are always on duty at visiting hours to answer relatives' questions.

Efficiency is perhaps best illustrated in the outpatients department. In Britain, the outpatients department has, since the launching of the National Health Service, provided the central problem of the patient-hospital relationship. It may be worth while recapitulating the problem briefly. Before the National Health Service was launched, outpatient departments were attended by casualties, and by people who could not afford to pay for a specialist consultation. For their sake the majority of specialists gave their services to hospitals free. The National Health Service put the outpatients department, with its consultants now paid, at the disposal of every single person in the country. Even those patients who still pay to see a consultant privately are frequently passed by him to the outpatients department

A canteen is provided for outpatients. Here a Lady Almoner talks to one of the patients in the radiotherapy canteen.

This mobile shop is taken around the wards by a volunteer. From it patients can buy such things as toothbrushes.



of a great teaching hospital because only there can they have certain highly specialized treatment.

The result is that during 1953 alone there were 27,000,000 attendances in outpatient departments, and 6,500,000 *new* patients. This means that, for the vast majority of people, the outpatients department is the first introduction to the hospital; therefore, from the hospital's point of view, it is important to establish a good patient relationship there. It also means that a more vocal section of the population has been brought into contact with hospitals, and has pressed for reforms in the outpatients system.

The worst complaints were, in brief, that however great the kindness shown by any given hospital to its inpatients, it was not always extended to outpatients; that no one seemed to mind if outpatients were kept waiting all day, and that lack of proper organization and accommodation made nurses and patients edgy and harassed.

Prodded on the one side by the general public and on the other by the Ministry of Health, which has issued general guidance as to standards to be aimed at, hospitals all over Britain are trying to make improvements in the outpatients departments.

The fundamental difficulty is making an appointments system. The hospital consultant knows even less than the general practitioner how long a new patient will take, and his time is too precious to be wasted because there is no patient to be seen. In a teaching hospital, a flow of patients is particularly necessary, in order to make teaching by the consultant holding the clinic both interesting and continuous.

At the Middlesex there is a different appointments system for each clinic, evolved after discussion with the consultant. Generally, appointments are made to the nearest quarter of an hour, although an extra patient per hour may be called in case another fails to turn up. Waiting cannot be completely eliminated in any branch of medicine, but the old system of calling all patients at 10 a.m. and keeping them waiting until 4 p.m. can be and is being done away with at many hospitals.

In any case, much can be done to make waiting less exacting. At the Middlesex it is realized that new patients may feel lost in the machinery of registration and transfer from room to room. But they are never allowed to feel that they have been forgotten. The key person here is the clinic receptionist, a member of the administrative staff who not only handles records and reports, but talks to patients and explains the next stage in the procedure to them. And, of course, in the waiting period, diversions are provided by reading matter and the ubiquitous cups of tea.

Other hospitals, with old premises, have felt it worth while to rebuild and reequip their outpatients departments, to carpet them and furnish waiting rooms like rooms in private homes. Sometimes, too, they provide trolley meals for patients who have to wait over the lunch hour. These additions of comfort and service to treatment are other ways of expressing the belief that the patient is a guest and an individual.

It is the attitude which, fundamentally, distinguishes the successful hospital-patient relationship from the unsuccessful. One of the most widespread grouses against hospitals has been, in the past, that "they treat me as if I were a fool or a child, or both." While it is admitted that the adult population does contain its quota of fools and children, the whole trend of patient technics today is toward treating the patient as a mature person. This treatment is extended as far as mental hospitals, and it is believed to succeed.

It is also part of a conscious reaction against the growing size and ramifications of a modern hospital. Some, even many, hospitals have in the past insisted that size necessarily involved uniformity, conformity and mass regulations. Happily, the Middlesex and other hospitals have never accepted this view. They have made a constant and conscious effort to treat and respect every patient as an individual human being. It is a very simple principle, but it is also a very difficult principle, because it makes enormous demands on both the efficiency and the imagination of the people who hold it.

Scottish Hospital Looks Colorful, Not Clinical

THE account of Britain's first postwar hospital at Alexandria, Dumbartonshire, Scotland, published in August 1955, omitted one of its most striking characteristics. It is true that outwardly the buildings give a pleasing impression of color, light and space, but it seems even more significant that their interiors reveal a new and refreshing approach to the needs and comforts of patients and staff alike.

At the Scottish Design Congress held in Edinburgh last year, Llewelyn Davies of the Nuffield Foundation remarked that it is time to get away from the timid, pastel color schemes that still persist in most hospitals. He urged that more attention be paid soft furnishings and that many sections of the hospital should be furnished in a more humane and less clinical manner than was formerly the case.

For the new hospital in Alexandria, on the bonnie, bonnie banks of Loch Lomond, the furnishings of wards, waiting rooms, sitting rooms and private rooms are the work of leading contemporary designers. There is individuality in the nurses' rooms as to draperies and to chairs. The wards have colorful and patterned window draperies, and the curtains dividing off the beds are self-colored.

Residential quarters are also colorful. There are private suites for the matron, assistant matron, and the resident doctors.—DONALD S. FENWICK, *London editor, Scotnews Limited.*

Gaily decorated ward at Alexandria Hospital, Dumbartonshire, Scotland.

Special Report

CONVENTIONS IN THE HOSPITAL FIELD

Conventions are part of the life of every hospital administrator. The dates of state, regional and national conventions are marked on his calendar months in advance. As the date approaches he looks forward to each convention as a time of release from the pressures of his daily routine, a time of excitement, professional stimulation and companionship, education and fun.

Sometimes the hospital convention is everything the administrator expects it to be—escape, education and entertainment in a single, exhausting package. More often than not, however, the administrator finds himself on the second or third day of a convention, like a child at eleven o'clock on Christmas morning, wondering if this is all there is. With the new-sounding titles removed, these are the same old speeches and discussions he has heard before. If, as some do, he attends two or three conventions a year, even the fun may wear thin.

When attendance lags and conventioners are more bored than stimulated, the man who pays the bills, the exhibitor, isn't getting his money's worth, either. At this kind of convention the exhibitor and his representatives may be idle much of the time, or, at best, they may keep themselves occupied demonstrating their merchandise to unclassified visitors, many of whom are prospects for nothing more than the free samples that are handed out on the exhibit floor. As one exhibitor said following a recent convention, "You never knew whether the person coming into your exhibit was a customer, a competitor, a student nurse, a trustee, a dietitian, or somebody who just came in off the street to get warm."

Good or bad, a convention is paid for by visitors with something to learn and exhibitors with something to sell. Thus the cost of conventions is ultimately reflected in the prices of goods and services bought by the hospital—and hence in hospital bills. Unquestionably, the public gets the benefit of a good convention at which everybody learns and is stimulated. But the public is the loser when a convention falls flat.

To find out what those responsible for planning and staging hospital conventions can do to improve them, The MODERN HOSPITAL interviewed several men who have made a career of convention and conference planning and have had experience with numerous conventions in the hospital and many other fields. We also asked these men what the convention-goer can do to get more for himself, and his hospital, out of the meetings and discussions that have been planned for him. The results of these interviews are reported in the following pages, along with some sharp observations and opinions solicited from a group of men who probably analyze conventions more carefully than any of the rest of us—representatives of the hospital industries.

As we say at conventions, these men need no introduction to the hospital field. Unlike most convention speeches, however, what they have to say here hasn't been said before, and it needed saying.

—THE EDITOR

Special Report

CONVENTIONS IN THE HOSPITAL FIELD

B. P. BRODINSKY

PLANNING and conducting a hospital convention may cost anywhere from a few hundred dollars to a hundred thousand or more—when all the time, money and effort put into it are counted, to say nothing of the time and expense of delegates.

No one would think of constructing a building worth even a few thousand without first having a blueprint. Yet, too many conventions suffer from inadequate planning.

It's time to take a closer look at this expenditure of time, effort and money and see how conventions can be made better.

First of all, we must ask: Is the convention necessary in modern times, or can we develop something new to take its place?

"The convention is here to stay for a long time," one authority told The MODERN HOSPITAL. "First, because of its long tradition; second, because many constitutions of national organizations provide for it. But, most important of all, the big meeting can perform a useful function.

"It can bring a welcome change in daily routine. It can help the person see himself in a different light. The convention can inform people, inspire them, and show that every one of us is facing common problems. A convention is a good tonic to help do away with that feeling of self-pity. It can demonstrate to all of us that we are facing tough problems, that each of us is struggling to find a solution, and that no one has any magic answers."

If the convention is to do its proper job, however, it must change. Fortunately, convention planning is shifting gears.

• • •

CONVENTION management has, in fact, reached the stages of an art and science. One of its practitioners is Richard Beckhard. Mr. Beckhard is executive director of Conference Counselors, in New York City, and has assisted in planning, and stage-managing, several conventions of the American Hospital Association in recent years. I had a long talk recently with Mr. Beckhard, seeking answers to some of the questions that have been raised about conventions today.

Here are some of the questions I asked and the answers Mr. Beckhard gave:

Q: Just how good are conventions today when measured against the yardstick of what we know conventions *should* be?

A: They're much better than they used to be. But they're not as good as they can be. Perhaps we can say this: The *national* meetings are getting better all the time, but there's lots of room for improvement in smaller conventions.

Q: What's wrong with the average convention?

A: I can answer that question by giving you a brief picture of what happens.

Mistakes Begin in Planning

Q: Where do the mistakes begin?

A: First, in the planning. The planners often are doing this for the first time, and therefore feel quite insecure. This generally leads to their figuring that what had been done the year before is probably the best kind of thing to do. After all, it had come off and had worked pretty well. Therefore, why not do the same thing again?

Here is what happens so frequently: Some weeks before the convention deadline, its planners sit and say: "First we will have an address by the local host, then a welcoming speech by the president."

All of us know that this will be a *long* speech. Last year's speech was a long one, and the previous year's was, too. This is what's expected.

Then will come a big-name speaker from the outside who may develop at length some such topic as "The Meaning of Health Today." The first session will end on this uplifting, but not necessarily practical, note. In the afternoon will come the inevitable time consuming reports, which actually each member could have sat down and read by himself.

"What shall we do the second day?" the convention planners will then ask themselves. They will provide time for panel or committee reports, during which leaders will make three or four short speeches. Then will follow the questions. Out of three to four hundred people in attendance, or up to 1000 in some meetings, five or six may get up courage to ask questions. With so many people, it's lonely to stand up all by oneself. But inevitably you will find the professional question-asker who is so infatuated with his own voice that he makes speeches instead of asking questions.

That will bring the end of the morning of the second day. For the afternoon, the planners will usually provide time for a business meeting. And, in the evening, a windup banquet and another big-name speaker. "Where can we get a good speaker?" the planners will keep asking, this being one of the most important questions for the traditional convention managers.

Q: I gather you don't approve of this pattern. Can you give a snapshot of the kind of convention you think will be more productive?

A: The productive convention is also planned by a group of headquarters people, but with the help of the entire membership of the organization. And the way to get all the members into the planning is to ask them: What are your questions? What are your problems? What is bothering you? What kind of help do you want to get from the convention?

On the basis of the answers that the members mail in, the headquarters

staff can work out the agenda. The keynote speech (and I suppose the keynote speech will always be with us) can then deal with the main issues that have been named by the members. The panels and discussion groups will also deal with the topics that are very much on the minds of the people who come to the meeting. Finally, the question and answer session will by no means be left to chance.

Q: Do you mean that the questions are prepared in advance?

A: No. It has been worked out this way, for example. While the panel speakers are discussing the problem, the audience is asked to jot down questions on 3 by 5 cards. These are collected by ushers during the progress of the discussion, sent to the speakers' table, and sorted out quickly. The most commonly occurring questions are given to the leaders for reply. Thus, instead of the seven questions usually answered, at the new type of convention several dozen questions will be answered.

Q: Does the pattern that you have just described seem to satisfy the modern convention-goer?

Want Chance to Talk to Someone

A: Yes—it does, but only in part. What the participant wants today at a convention is the chance to talk to someone. It satisfies him but little to be raising his hand now and then as a sign that he is voting Aye or Nay. He wants to take part in the discussion and in the formulation of policy. The good convention meets this need. It makes time and provides room for face-to-face discussions. It creates opportunities for small groups of people to exchange ideas.

Q: Would you say that the kind of convention you just described does away with the common gripes we hear against the big meeting?

A: Not altogether. But certainly we get less criticism from people who come to the new type of convention. After all, what are the chief gripes against the big meeting? You can count them on your five fingers: (1) too many speeches; (2) program too rushed; (3) chairs too hard; (4) I didn't learn much; (5) nothing was really accomplished.

You can classify complaints into two or three categories. First, there are complaints against the physical surroundings—if the chairs weren't too hard, they may have been too soft, or the light was too strong, or the room was stuffy. The second category of complaints centers upon the fact that the participant wasn't really a participant but an observer.

A piece of research by the University of Buffalo underscores this conclusion. An investigator from Buffalo studied the 1954 convention of the American Personnel and Guidance Association. He found from interviews that members disliked most the manner in which meetings were conducted. "They are too formal, and there is not enough time for discussion," the members complained. Nearly half of those interviewed wanted smaller groups and more informal meetings. And they wanted more free time for informal contacts.

On this point Mr. Beckhard summed up the steps that need to be taken to improve conventions.

1. We must first understand that a good convention deals with the problems of the members, rather than the problems of its officers and leaders. "We must change our points of view. We must think first of what the consumer, that is, the participant, should get out of the convention rather than the planner," he said.

2. We must make as much use of the talents of the members as possible in building the program for the meeting.

3. We must find ways to involve the entire membership in planning the meeting.

4. We must devise methods for maximum audience participation. "We must do away with the convention during which members sit on their hands except when they applaud or vote," Mr. Beckhard said.

Finally, we will get better conventions if we start not with the details of writing a program but with an understanding of what members need and how the convention can meet that need.

The sit-and-listen type of convention is on the way out. The new type, characterized by more activity, more participation, more freedom, is becoming accepted by hospital leaders.

At the same time, research and experimentation for better conventions are moving ahead. We now know:

1. How to plan effectively with members of a statewide or nationwide organization.

2. How to get more audience participation during the convention.

3. What types of platform presentations are more desirable than speeches.

4. How the convention-goer can be assured of more satisfactory physical surroundings.

5. How to evaluate the effectiveness of the meeting after it's over—and the technics for postmortems are most ingenious.

There was a time when a man could relax at the big convention. He could attend the sessions or not as he wished; he could sit in the front row and take notes; he could sit in the rear seats, doodling; he could lose himself in the lobbies or corridors of the convention halls, chatting, browsing, attending to personal business.

Don't Just Sit There!

This era of relaxation and self-effacement is passing. The researcher in group action and the expert convention planner believe that the administrator who comes to a convention should make the best possible use of his time and the money he is investing. And the best use of this investment is not simply to sit and get exposed to streams of words from platform speakers. The new conviction is that convention-goers should think, talk, discuss, work, solve problems, exchange ideas, evaluate policies, make notes for the folk back home.

Many associations throughout the country are seeking ways to improve the large meeting. Today in any organization the problems grow more numerous and complex. To cope with them requires time, skill, energy. There is always the danger that a small group of manipulators, politicos, kingmakers —call them what you will—will step in to take over policy and decision making. The individuals will get lost and obscured. There is also danger that the people who come to a convention where a year's budget action and policy are to be decided will be among the loneliest of the "lonely crowds" becoming so frequent in American life.

The improvement of the large meeting, therefore, is a service in the improvement of democracy. If we would save the individual from organizational oblivion, we must give attention to the technics that are being tested and tried to improve the large meeting.

Such improvement concerns itself with planning, presentation, participation and postmortem, or evaluation. This series of alliteratives suggests another one: A good convention concerns itself with purposes, people and processes. Enough is suggested by these

words to show that building a convention consists of more than drawing up a list of speakers and sending out announcements. The good convention sets up conditions under which the individual will get something *and* give something.

Get something—this implies such effective presentation of material that the delegate will feel the convention was designed with his problems in mind. **Give something**—this implies that the convention should be so designed that the individual will have opportunities for participation. Let's look first at some of the better ways of presenting facts, issues, inspiration and ideas at the big meeting.

First, the newer type of convention "warms up" its delegates with advance information. The burden does not fall entirely on the platform speakers. The convention-goer is asked to assume some responsibility for acquainting himself with the problems of his association.

Of platform presentations, the speech is still the main staple. Even though many association members say that they want fewer speeches, their programs are still made up primarily of big name or little name speakers. "One reason for this," says Mr. Beckhard, a pioneer in convention management, "is that many planners do not feel secure in trying other methods of presentation. Another reason is that it is difficult to determine what other method to use.

What to Do About Speakers

Improve the speech and the speaker. Perhaps still another reason is that the speech is an enormously useful and economical device. It is not to be belittled. It can, however, be improved. And the convention planner, who is concerned about the convention-goer, is doing something about the speech and the speaker. He guides the speaker during the preparation of his paper and helps him prepare for more effective presentation. He tells him what kind of an audience to expect and what the audience will expect of him. He shows the speaker how his particular talk will fit into the over-all program. Finally, the good convention planner provides opportunity for speech rehearsals so that the man who will give the talk (usually an expert in anything but oratory) will become comfortable on the stage or before the lectern.

The weakness of many a convention is its reliance on the speech as the sole medium of presentation. In the new type of convention the speech is used for selected purposes. A committee of the Adult Education Association has found the speech "most useful for giving information, for bringing the experience of an expert to the audience, and for inspiring the audience." The speech, this committee continues, "has received an undeserved bad name because it has frequently been asked to do jobs it can't be expected to accomplish."

When you want the convention session to do a special job, use technics other than speech, say convention doctors. Here is what they prescribe:

When it's necessary to present controversial issues before a group, use the panel. The panel (three or four speakers and a moderator) provides an interplay of ideas.

When it's necessary to present complex technical material (organization,

Manufacturers and Suppliers Give Views on Conventions

Hold Conventions With Exhibits Alternate Years

L. H. NICHOLS
Bauer & Black
Chicago

EXHIBITORS QUITE GENERALLY feel that the cost of conventions has reached uneconomic heights. They are expensive in money and manpower, and inevitably add to the cost of doing business, thus having an inflationary effect on prices. The same volume of supplies can be bought and sold at lower cost through regular sales channels.


L. H. NICHOLS

It has been suggested that national and regional conventions with exhibits might be scheduled on alternate years, with any intervening meetings paid for by means other than subscriptions from commercial firms. That idea is worth consideration. On many commodities, one opportunity per year to see products displayed in a booth may be sufficient, and the cost of distribution goes up with every additional exhibit.

If for any reason this ideal cannot be achieved, it would be desirable to limit the maximum number of conventions with exhibits per year to one national and (in each section of the country) one regional. State associations should be encouraged not to hold independent exhibit-conventions, but to consolidate with near-by regions. As a general rule, their conventions are not large enough to justify the time and expense. Some states are still holding independent conventions with exhibits, even when they also belong to regional associations. All this increases the cost of distribution and, in the long run, prices.

Conventions held on "luxury liner" steamships raise costs like all others, and also may present some disadvantages from the standpoint of public relations.

To give value received in exchange for exhibitors' fairly substantial contributions, associations should make it possible for delegates to spend a liberal amount of time visiting booths. At some, booth attendance is a farce. One or two conventions give exhibitors their money's worth, and their methods could profitably be studied by others.

Conventions Are Desirable for Building Contacts

RICHARD B. SELLARS
Ethicon Suture Laboratories, Inc.
New Brunswick, N.J.

AN ANALYSIS OF OUR OWN HOSpital convention schedule here at Ethicon indicates we are spending annually some $34,000 for medical, surgical and hospital conventions. This figure includes space, purchase of exhibits, and their transportation and storage. A little less than half, or approximately $16,000 per year, is


RICHARD B. SELLARS

processes, mechanics), use a speaker with a visual exhibit.

When it's necessary to demonstrate a skill or technic, act it out in front of the audience with a film or with live actors.

Let the Characters Speak Their Minds

The National Training Laboratory in Group Development has popularized (through its work at Bethel, Maine) an effective type of convention presentation, utilizing a special gimmick (sometimes called "rôle playing"). This presentation is designed to lay bare the inner conflicts surrounding an issue and to bring the hidden forces into the open. For example, suppose a group discussion is set up to consider specific hospital problems in a community. The arguments for and against can be easily stated on the platform by persons *acting* as the administrator, trustees and doctors. The gimmick comes in furnishing each character with an alter ego or ghost voice. So that while each character speaks his piece for public consumption, each alter ego speaks what is really on the person's mind. There are no dull moments during such a session.

The tool kit of the convention planner who is serious about bringing new life to the meeting is ample and varied. To sum up, there are the speech, the panel, the visual exhibit, the demonstration, the dramatic presentation. Add to these the symposium, the forum, the film showing; add, too, the filmstrip, the animated chart, the flannelboard, the opaque projector; add, too, the rôle playing scene, the question and answer session, the illustrated chalk talk—and the wonder grows why conventions need to be dull.

"Most of the participation at a large hospital convention takes place outside the official orbit of the meeting."

This is the belief of Ronald Lippitt of the University of Michigan Research Center for Group Dynamics.

Sideline discussions are creative. The people who meet in the halls, who congregate on the boardwalks, who talk at lunch are actually taking an active and creative part in convention proceedings. The traditional convention does not provide any opportunities for channeling this creative thinking into the larger convention settings, Dr. Lippitt said during an interview. He stressed the word "creative."

Tapping That Gold Mine—the Delegate

How do we know that this sideline discussion is creative? From observation! But at least one enterprising social researcher made a study of what he called "overhearing." By placing hidden microphones in the hallways, cocktail lounge, and other public places frequented by conventioneers, this researcher came to the conclusion that the so-called casual talk was actually of a high professional level. People poured out their thoughts, their plans, their ideas. In the small informal settings the convention-goer was finding outlets that were not provided for him in the official mechanism of the meeting.

How can the enormously rich creativity that delegates bring with them be tapped? How can it be put to work for the solution of problems? Many people—both theorists and practitioners—are concerned with these problems. Men like Leland Bradford,

Too Many Conventions? Here's What the Exhibitors Think

devoted to the hospital conventions. The annual meetings of the American Hospital Association and the Catholic Hospital Association are the two major meetings which are always well attended by our Ethicon organization. In addition, we exhibit at some 10 or 11 sectional meetings . . . and by and large find them profitable sales and promotional activities.

Our sectional and regional hospital conventions are usually only attended by the local representatives who generally employ their time most advantageously in further strengthening their relationship with the key hospital personnel. Most conventions provide a highly desirable, informal atmosphere for really building the contacts that otherwise might be far more difficult and expensive to establish.

It has been suggested by some that "too many conventions take too many people away from their jobs too often, for too long a time." I do not believe this to be the case at Ethicon. Our present schedule would indicate that there are not too many conventions, and inasmuch as the regional or sectional convention exhibits are staffed by the local field representatives it is not taking the man away from the job. This is part of his assigned responsibility. The time element devoted to conventions is not excessive in our opinion. A large number of our field representatives only attend one hospital convention a year. Some 40 per cent of our field staff may attend two hospital conventions a year, and an even smaller number would at most attend three hospital conventions.

In addition, our New Brunswick executive organization does not attempt to cover more than two or three of the major meetings, and then when they are only relatively close to our Eastern headquarters area.

Conventions at Best Are Helpful, But Help!

CHARLES T. RIALL
Davis & Geck, Inc.
Danbury, Conn.

NATURALLY WE FIND CONVENTIONS at their best very helpful in reaching many people who would be difficult to see at other times. However, we look with great alarm on the tremendous number of new conventions that seem to rise out of thin air every year. Each commands our attention with the statement that we would be sacrificing a good part of our business if we did not cooperate with it, pointing out the need for distribution through its customers.

CHARLES T. RIALL

The suggestion that groups confine themselves to national meetings one year and sectional meetings on the alternate year is excellent; considering the cost of maintaining a sales force and the value of an hour's time for these men, it certainly behooves us to make use of every minute of a salesman's time. While a man is attending a convention, obviously he cannot be in his own territory attending to his individual business. Estimating that it costs about $60 per day for a sales-

Kenneth Benne, Malcolm Knowles, Richard Beckhard—and they have the happy combination of both theory and successful practice—have attempted a variety of devices to get greater participation so that the individual will have the opportunity to give of his mind, heart and experience.

But of the many devices attempted, there is one that stands out supreme. People will take an active part in a convention if they feel that the meeting is concerned with their problems and not with the problems of some nebulous "leadership." This implies that involvement of audience members will start before the meeting begins. It will start on the day the convention planners begin to make a census of what troubles the members, and it will continue throughout the preparation of the agenda or program. If the program deals with vital issues in which the individual has a stake, the convention is almost certain to be active. No one will feel left out.

But many good convention managers go further. They seek the active collaboration of the audience and platform leaders at every session. Let's look at some examples of methods for increasing participation by the members of the audience.

Briefing and Preparing the Audience

Listeners with a purpose. Before the speech or demonstration takes place on the platform, the chairman asks the audience to listen with specific purposes in mind. Sector A of the audience may be asked to listen for areas of agreement in the issues being discussed; Sector B, for areas of disagreement; Sector C, for points about which further data are needed; Sector D, for points needing clarification. Each sector of the audience is asked to appoint a reporter who transmits the findings of the listening teams to the entire meeting.

Questioners with pencil. Provide each member in the audience with a pad on which to write questions as they occur to him, and you have involved him in the platform presentation. Of course, facilities must be set up for answering the questions or at least giving recognition to their existence. It's worth doing. The simple question has been found to be a most effective "hook" for drawing members deep into the proceedings.

Buzzers with their neighbors. The buzz group has been one of the most widely publicized technics for bringing an audience into the middle of things. This device deserves its popularity. When it is properly explained by the leader and when it is properly understood by the audience, the buzz session can be a fruitful and valuable device.

Best results are usually obtained by dividing the audience into small groups of from six to eight persons, by asking that they consider a specific issue within an allotted time and report (through some prearranged method) their conclusions. The person sitting in an assemblage even as large as 1000 or more will immediately get caught in the activity of this procedure.

Criticizers and reactors. Have you ever sat through a long reading of a technical paper, completely lost and confused, yet helpless to do anything about it? The modern convention offers an escape hatch. The leader of a meeting appoints a "reactor team."

"One thing that has helped has been the stagger system of exhibit hours"

man, you can easily understand our desire to make this type of operation as efficient as possible.

In Twenty Years: From 100 to 230 Conventions

FRANK M. RHATIGAN
American Surgical Trade Association
Chicago

TWENTY-THREE YEARS AGO I CONceived the idea of a schedule of conventions for the Medical Exhibitors Association; I was then its secretary. I think we had listed in the first schedule in 1933 something like 100 conventions in the medical, hospital and allied fields. The schedule published last November listed more than 230 conventions. That means 230 places at which to spend money for exhibiting. The reason there are too many conventions is that there are so many companies in our industry that will support any convention whether or not it actually means anything to them.

FRANK M. RHATIGAN

You will recall when every state hospital group had its own convention, and many of them had exhibits. None of them was worth while from an exhibiting standpoint and I doubt if they were worth much from a convention and program standpoint. Finally they got together into sectional groups, and now they can justify an annual convention for that group and get large enough audiences to get speakers of high caliber, something they couldn't do before.

It has always been a mystery to me how some people find time enough to go to all the conventions that they do. In my particular case over the years I was paid for going. I believe that the answer to too many conventions lies with the hospital personnel or doctors who attend. If they do not go and the attendance is poor, the exhibitor will not buy space, and if the exhibitor does not buy space the association does not have the money to put on a convention and would have to put it on at the expense of the membership, which is very difficult.

The exhibitors have it within their power to cut down on the number of conventions and make it difficult for new ones to come into the field. All they need to do is not exhibit, and the association will not have the necessary funds to carry out a convention.

One of the steps that has helped make conventions satisfactory from both the conventioneer's and the exhibitor's point of view has been the stagger system of hours for viewing the exhibits and the elimination of conflict between the technical exhibits and the program.

Fewer Meetings Would Mean Better Ones

ROGER WILDE
Simmons Company
Chicago

I THINK THERE ARE TOO MANY hospital meetings at which manufacturers and dealers are asked to take exhibit space. Expenses in connection

It is the duty of the members of this team to be on the lookout for points that seem unclear to them. They have the privilege of interrupting the presentation so that the fuzzy points can be cleared up.

Warmer-uppers. Frequently a platform presentation leaves an audience so cold, the people appear to be sitting on their hands just to keep them warm. No questions; no reactions. When that happens, the leader invites three or four people to the platform for a "warming up" talk. After the thaw, members of the audience pick up the discussion.

I have described some examples of audience involvement technics which have been successful because they are essentially simple. In the near future, convention planners foresee the use of mechanical devices to get the audience "to give." Within the next few years you'll probably attend conventions where the following will take place:

1. Delegates will sit at seats equipped with push buttons through which they'll "send" to the platform signs of their reaction to what's going on on the platform. A red button, flashing a corresponding light to the platform, may signify disagreement; a green button, agreement; a yellow button, confusion or need for clarification.

2. Attendants will roam through the large convention hall equipped with walkie-talkie or field telephones. Through these instruments members of the audience will be able to communicate either to the platform or to the audience at large. The advantage of this device, Dr. Lippitt points out, is that it can provide anonymity for the questioner—a condition fervently desired by some convention-goers.

3. Convention-goers will have a wide choice of closed circuit television programs describing, exhibiting or demonstrating projects or problems of interest to the convention. Such television showings will permit delegates to comment or ask questions about the program while it is going on. The good convention results from a series of interlocking steps.

Good presentation encourages participation. Participation is enhanced by proper planning. For that reason I shall look at planning later in this discussion.

Meanwhile, if some of the audience involvement technics described still seem complicated, here is a suggestion from Dr. Lippitt: "A simple audience participation device, as well as one that should bring some reaction, is simply to ask everyone to sit quietly for five minutes and think about the talk or demonstration they have just heard."

Silence as well as talk can be an instrument for the good convention.

Ask the Man Who Knows Conventions

Last fall, Atlantic City was host to the convention of the American Hospital Association; this month, it'll be the convention of the American Association of School Administrators. Like the billows against its shores, wave after wave of conventioneers keep and will keep going to that city. It is not surprising that its denizens and hosts have become convention-wise. One such personage is E. D. Parrish, a major domo of the Chalfonte-Haddon Hall. We mention him

"We go because it is good business; when it ceases to be, we won't"

with these exhibits are constantly increasing and the results do not justify the expense. I am very certain, from the exhibitors' point of view, it would be much better if national meetings were held every other year and in the off year the regional meetings took place. This would cut the exhibitors' expense in half. From the point of view of hospital personnel, it would seem to me that national meetings every other year would be sufficient at least for meetings at which exhibits were included, and more people would go to them if they were not held so frequently. On the other hand, in the off years, the attendance at the regional shows would also increase. This should make it possible to obtain better talent and programs which would also help to draw greater attendance, which is desirable from the point of view of the hospitals as well as the exhibitors.

ROGER WILDE

Overlap of Conventions Is Exhibitors' Problem

D. WAYNE JOHNSON
Becton, Dickinson and Company
Rutherford, N.J.

THE MATTER OF CONVENTIONS IS extremely serious. There are, unquestionably, too many of them. There are too many overlaps and I believe many exhibitors feel they are not getting their money's worth.

D. WAYNE JOHNSON

In the final analysis we go to conventions because we think it is good business to do so. When it ceases to be, we won't or can't. We should not, however, be subjected to undue pressure to attend certain conventions when good judgment indicates we should not.

There have been instances when we have attempted, for excellent reasons, to cancel out on a convention and have been threatened with a loss of substantial business if we did so. In some cases we have had to submit, or thought we had, and in others we have not but, needless to say, this should not happen.

We do not consider that we are doing anyone or any group a favor. It is a program in our mutual interest. We, of course, try in every way possible to contribute to and cooperate with the groups that are working in the over-all interests of the entire industry.

It is becoming increasingly impossible, however, for us to make every meeting of every group in every part of the country every time one of them decides it wants to hold a meeting. There should be more combined meetings of the various groups, and it would seem to me that some kind of controlled program will have to be worked out; many meetings that are now planned at the same time will have to get together when making up their schedules.

It might also be possible in a controlled plan for certain state and regional meetings to be held every other

not to the exclusion of other hotel officials, but simply because Mr. Parrish has taken the trouble to jot down his ideas on how to improve conventions.

Advice From Hotel Man

"First thing that needs improvement about conventions," Mr. Parrish likes to say, "is the convention delegate."

Mine host Mr. Parrish can back up this statement because, as he says, "It is often shocking to see how many delegates waste opportunities that a convention opens up before them." To prevent such waste, Mr. Parrish has a few suggestions for delegates:

"Plan your own participation in the convention from the moment you decide to attend.

"Check over personalities appearing on the program. Are there men whose experience makes them able to give you a general steer in the right direction? Make sure you attend their sessions and, if necessary for additional information, see them afterward.

"Jot down specific problems that now confront you in your hospital. Plan to find men at the convention who can discuss them and help find a solution."

This down-to-the-sands wisdom places a proper amount of responsibility on the individual delegate. What Mr. Parrish may or may not concede is that the second thing needing improvement is the person who plans conventions. *Persons* would be more accurate, because today convention planning is a function of many individuals—the goal, yet unattained, being the involvement of all members of an association.

Those who are responsible for the convention are giving a lot of thought to improving their own philosophy and practices in setting up the year's big meeting. In this they are not unique. Business, fraternal, social service and other interests are also reconsidering the investment of time, effort and money that goes into conventions. Businessmen spend some $2 billion a year for meetings, conferences and conventions. Trade, fraternal, service and professional groups attract 10 million conventioneering Americans annually.

Businessman, superintendent, grand potentate—all are beginning to wonder whether the convention is growing out of proportion to its value. If so, can the good and the unique in the convention be grasped and expanded and the remainder discarded? Can the convention perform a service for people which no other medium can perform?

Razzle-Dazzle Alone Won't Do It

It is such questions as the foregoing that have led many to think, experiment and test different ideas of planning and running a convention. We have already seen how some of the innovations in convention management have been introduced. But all the razzle-dazzle (new type) of discussion groups, panels, buzz sessions, film showings, and exhibits that characterize the modern convention will be an empty show unless the convention is built so that it answers the questions and solves the problems of delegates.

This places the burden on good planning. And to round out these brief discussions on the modern convention we shall take a look at ways to determine whether the modern convention lives up to its promises.

"If the medical and hospital associations don't do something, we will"

year. In this way the manufacturer could make a much more equitable distribution of his time and his support. If the hospitals don't do something of this kind, the exhibitors will have to do it—to the dissatisfaction of the various hospital groups.

There is one other angle to this convention problem that is causing more and more concern with us: the overlap of medical and hospital conventions. We have had as many as four conventions going at one time in the same area. If the medical and hospital associations don't do something about it, we are going to have to. We just don't have that many men to spare all at once, to say nothing of the expense.

H.I.A. Trying to Correct Convention Abuses

JAMES F. ROBINSON
Surgical Supply Center
Salt Lake City, Utah

OF COURSE THERE ARE TOO MANY conventions. In some areas there may be too many hospitals, too many dealers, too many manufacturers. To justify your existence in any of these fields, problems must be faced squarely. Usually if a problem is faced squarely, it can be solved.

JAMES F. ROBINSON

Can anyone criticize the hospital administrator who gets the idea that huge profits are made on medical, surgical and hospital supply equipment? Put yourself in the position of this administrator. What would you think when you walked in the exhibit hall and saw the lavish displays? When you found manufacturers competing against one another with extravagant parties, private entertaining, prepaying rooms, and other expenses?

I know the H.I.A. has been trying to correct abuses. How well has it succeeded? The policy of excluding nonexhibiting dealers from the convention has not worked well. Members of this organization must not be 100 per cent in agreement because I frequently see *them* violating the rule. It looks a little silly to see a man you know as Joe Blow wearing a badge that says he is a Bill Smith of such and such company.

Way to Overcome Ills Is by Education

CARROLL RUTLEDGE
E. H. McClure Company
Dallas, Tex.

I THINK THAT RATHER THAN DO away with hospital conventions with exhibits, many of the ills now existing could be overcome through a process of education. I have been on the exhibit committee of the Texas Hospital Association for three years and have worked with Ruth Barnhart, secretary, and three presidents of T.H.A.

CARROLL RUTLEDGE

Prior to this last meeting of the T.H.A., I suggested to the group that they do something similar to what we

IF YOU will glance again at the suggestions of Mr. Parrish, you will note he urges you to plan your own participation, to check over the program to see whether the men appearing on the program will be talking about your problems, to search for men who can help you with problems confronting your hospital. All this *after* you've arrived at the convention hotel.

On the basis of his long experience, Mr. Parrish knows that there has been a wide gap between those who had planned the convention and those who attended it. He knows that, in the past, the man who opened up a convention program was opening a hitherto secret document. All too frequently the program was conceived by an unseen leadership and outlined in isolation. Topics for discussion were chosen because the planners thought they were timely; speakers were selected chiefly on the basis of availability. Under such a regimen, Mr. Parrish's suggestions for getting the most out of a convention were not only common sense, they were imperatives.

The modern convention planner has a set of imperatives designed to change the old order.

Let's look at some of these and cast about for examples in which they have been followed successfully:

IMPERATIVE 1: Take plenty of time to develop what the convention objectives should be.

Warren Schmidt, who heads the department of conferences for the University of California, says: "The most common weakness we run into in working with planning committees is their hesitancy to spend planning time on the development of conference objectives. It is so much easier to decide on physical arrangements, list impressive speakers, and develop a whole series of program events which are then tied together under some abstract theme."

Experts believe the planning of a convention should be *slow, simmering, continuous.*

IMPERATIVE 2: Know your audience and know its problems.

Any live wire executive secretary or president of an association believes himself to be thoroughly familiar with his membership. Otherwise he wouldn't be in the position he is; right? But this sort of bravado portends failure for a convention program. The association executive may imagine that he had found out something about the members and their problems at the last annual convention. But what is worrying the people today? Because last year's session was well attended does not mean the next convention and all those thereafter need to make time and space for last year's theme.

Starting Point Is Census of Problems

"Ideally, the starting point of any convention should be a census of the problems uppermost on the minds of members," says Lyle W. Ashby, master planner of conventions for the National Education Association. We know of no national education group that meets this ideal. Many convention planners still play by ear, and catch the echoes of membership needs and problems from the four winds. Other convention planners try to get clues from more reliable sources.

(*Continued on Next Page*)

"Many firms are striving to outdo others in the entertainment field"

in the American Surgical Trade Association did in conjunction with publicizing our first manufacturers' exhibits in December 1953, which was to write our own members a letter urging them to go to the New York meeting prepared to place orders with the manufacturers who were exhibiting with us. We pounded away on this point, and the manufacturers indicated that they were very pleased with the response, and felt that their time and expense were repaid, not only by the contacts they made, but with the actual sales which they made at the convention.

I know there are many who would like to do away with exhibits altogether and take the position that they should merely go to these state hospital meetings for the purpose of "wining and dining" their pet customers. I cannot quite concur in this idea, however, although there is some merit to it, because I still feel that while many of these hospital purchasing agents and administrators enjoy the cocktails, nevertheless, sometime during the meeting they settle down to earth and for the most part are interested in seeing new items and newly developed products. It is true that the average purchasing agent of the hospital spends much of his time daily in talking to surgical salesmen and it is probably true that they would like to get away entirely from bedpans and hypodermic needles and "let their hair down" for two or three days.

In thinking of the two types of hospitals, that is, the larger and the smaller hospital, I still believe that through a process of education, the evils of convention practice could be corrected and made more profitable for the exhibitors, as well as worth while for the hospital people themselves.

Exhibits Are Good Ads—But We Need Curfews!

GEORGE T. BROTHERSTON
Brotherston Surgical Company
Philadelphia

IN REFERENCE TO THE EXHIBITIONS at the various hospital meetings, I find that each year our business diminishes and that many firms are striving to outdo every firm in the entertainment field, which is not a good practice. Not only does the exhibitor come in in the morning not feeling too well, but rarely does the administrator come around until about noon, and he spends very little time at the exhibit. For the last five years we have spent more on exhibits than the entire volume of business. We realize that exhibits are very good from an advertising point of view, but there should certainly be something done to try to curtail the cocktail parties. I know that you cannot legislate a man to bed at a certain hour, but certainly there should be some curfew whereby these parties would terminate by 11 p.m.


G. T. BROTHERSTON

We have stopped exhibiting at all the meetings with the exception of the meeting which comprises New

IMPERATIVE 3: Involve as many rank and file members in planning as possible.

When you ask members what they consider key problems and what they want discussed, you achieve several "desirables" at once, Richard Beckhard, conference counselor, points out. He lists some of these "desirables" as follows:

It makes the individual think about the meeting before he goes to it.

It makes the individual delegate feel important, in that his opinion was asked.

It increases the individual delegate's interest in the meeting because he has participated in planning part of it (even if he's just curious to see if his problem is actually discussed).

It gives the planners valuable information for agenda preparation.

It helps select priorities and allot time on the basis of degree of interest in a subject.

IMPERATIVE 4: Train leaders for the convention sessions.

The success of a convention is frequently decided before the convention opens. It is decided by the quality of training given to group leaders, resource persons, recorders and other convention personnel before the formal sessions begin. This is a preconvention step frequently overlooked by state and local groups.

"I cannot underscore too much the importance of bringing together the conference leadership team for at least a full day of final preparation," says Warren Schmidt, whose most recent "hit show" was helping direct the California Governor's Conference on Education last fall. "Three thousand delegates sat down for this two-day conference. Had the conference leadership not been thoroughly briefed, the meeting would have become a shambles. Even those who were at first skeptical about the value of the preconference orientation meeting became enthusiastic about it."

• • •

DURING many a convention session, just as you may be busy taking notes or looking at your watch, an association staff member may take a seat next to you and from outward appearances glance around the room. Actually, this person may be on a mission of evaluation. He is taking mental notes on the *process* of the meeting. He wants to know whether the audience is alert or listless; whether the chairman has created an atmosphere encouraging the audience to take part; whether the room is comfortable and adequate; whether the speakers are concerned with audience problems or with "covering" their notes.

This appraisal may then be checked with the appraisal of the group's leader. To these joint views will be added the results of similar spot checks. The observations represent an effort to spot weaknesses in convention operation to be improved in succeeding years.

Groups which want a bit more system and depth to their evaluation use a formal Conference Evaluation Chart. One such chart asked four questions: (1) In terms of your interests and expectations, would you rate this conference very unsatisfactory, satisfactory, good or excellent? (2) Were the matters worked on at this conference completely irrelevant, somewhat irrelevant, relevant, or highly relevant? (3) If

"Conventions—like Easter and Mother's Day—are big business"

York, New Jersey and Pennsylvania, and feel that we have derived very little benefit at these costly exhibits.

Should Be Committee to Screen Conventions

WILLIAM T. STOVER
Wm. T. Stover Co., Inc.
Little Rock, Ark.

TOO MANY CONVENTIONS TAKING too many people away from their jobs too often for too long a time. First, it is a condition of the times. Second, conventions—like Easter, Mother's Day and Christmas — are big business and a big industry and a highly commercialized one. It is my personal opinion that actually the people as well as exhibitors attend as the result of wide-awake public relations departments of various chambers of commerce, hotels and transportation

WILLIAM T. STOVER

interests. I think the majority of the people who attend can be described much as a football coach once described people who attend football games—50 per cent go for the free ride and just to be going; another 40 per cent go to see and be seen; 5 per cent go to get drunk, and the remaining 5 per cent go for the love of the game.

Let us now make an effort to break down the conventions that the surgical industry people are confronted with. We will start out with first the national meetings: in the hospital field, the American Hospital Association and the Catholic Hospital Association. Next, we have the various regional meetings; these are then broken down to the state hospital meetings. Next, we go to the medical field on a national basis, among which a few are the American Medical Association, orthopedic society, radiological societies, urological societies, and general practitioners societies.

Then we go again to the state meetings. To these we add the registered nurses association, practical nurses association, hospital accountants association, and medical technicians.

Now, let's give some further thought to where the dealer fits into this thing. First he is usually approached for exhibit space which sells at a price equivalent to, or even more than, the most valuable front footage on main street in the town or city where he is located. Next, after he has tied himself up with as many feet of this as his budget will permit, he is approached by the program committee for a contract for anywhere from a fourth-page ad to a two-page center insert. After this has been completed the dealer may think that this is the end—but, no!—he has yet at least one more opportunity to subscribe to the endeavor. The chairman of the ladies' banquet group then hits him for appropriate souvenirs to be placed at each of the banquet plates.

There was a time a good many years ago when a dealer would exhibit at a meeting and he would receive a considerable amount of business. However, this is now for the most part all past history, for the simple reason that the average institutions are solicited

you were to help plan the next conference, what would you aim for? (4) What are your general reactions to this conference?

Some evaluation charts are no bigger than a postal card; others run to three pages. Some of these instruments are used during the middle of a convention, some at the end. Their rôle is usually the same: to channel the opinions of the participant toward the association's leaders so that the next convention will be better.

Evaluation is a difficult art, and some organizations employ the services of expert conference leaders. (A body of such leaders is being trained summers at the National Training Laboratory in Group Development at Bethel, Maine.) The expert leader is not always satisfied with the simple evaluation chart. He believes the interview gives a more accurate measure of audience reaction. He will therefore select a sampling of several dozen (or several hundred) people and ask: "What problems did you bring that have not been dealt with?" "Are you planning to change your methods of work as a result of this meeting?" "In what ways can the meeting be more useful to you next year?" The questions are as varied as convention subjects—and as the people who attend.

The timing of the interview, too, can be varied. We have been talking about evaluation procedures carried on at the end of the meeting. But interviews can be held during the early stages of a meeting, during the middle, and at the end. Changes in a convention can be made right in the middle of it as a result of the interview reactions from delegates milling in the hallways.

"Each meeting planner must find the kinds of evaluation tools and procedures which are most practical and economical for his purpose," says Richard Beckhard.

Perhaps it isn't so much the technic that is important as the will to evaluate. When convention plans are whipped up in a short space of weeks, instead of months; when the days before the convention are hurly-burly; when the big worry of the planners is, will the speaker's plane be on time? —under such conditions the convention managers are little interested in what the delegates think. They'd rather not hear about *that*. They've got a show to put on and are worried about what happens on the stage. They have little time and inclination for measuring the effectiveness of a meeting under such circumstances.

Portmortem Session

Evaluation claims its rightful time and effort when planners are more concerned with the audience on the convention floor than with the performers on the stage. It is for this reason that the dedicated convention leader is not finished with a meeting unless he sets up a postmortem session. Here chairmen and resource persons, delegates and observers sit far into the night going over the strengths and weaknesses of convention procedures.

Postmortem has a dreary sound. When several delegates were invited to a postmortem session after a three-day meeting in Denver recently, one of them balked. "Look at it this way," pleaded an association official. "You're not going to a wake. We're asking you to be present at the birth of the next and better convention."

"Booths serve as spots to relax, meet friends and deposit souvenirs"

by every Tom, Dick and Harry for everything from disinfectant to air conditioning machines from everywhere —including surgical supply houses— within a radius of a thousand miles. As a result, their requirements are for the most part liquidated—and sometimes by placing contracts for months hence—and as a result when they attend a convention, unless it is some new and novel item, there is just no business left for them to place.

The expensive booths that have been purchased serve only as a spot for the visitors to relax after a grueling night —or as a common place to meet some friend—or as a depository for their souvenirs after they have gathered up such a quantity that they have become too burdensome to carry.

If the exhibitors would appoint a committee to screen these various and sundry conventions and exhibit only at the ones most worth while—and it would probably be surprising, if this were done, to find out just how few would merit this cooperation — that would be one answer. However, the pitfall is that at the national conventions, only the national houses would exhibit, with the possible exception of a few of the independent operators that happen to be in the area where the convention is being held.

State and Some Regional Groups Should Combine

J. J. EGAN
S. Blickman, Inc.
Weehawken, N.J.

I HAVE FELT FOR SOME TIME THAT there are too many conventions too close together. Most of them, with the exception of the A.H.A., are scheduled during the periods of the last week in March through April and into May. Because of overlapping it has been necessary sometimes to have a staff attending two conventions 1500 miles apart. The attendance in the booths has definitely dropped off within the last three years and a lot of us have the feeling while at these conventions that we are wasting our time and could be doing a much better job if we didn't have to spend this time in the booths talking to each other.

J. J. EGAN

I further feel that the few state conventions that are left should be grouped together with adjoining states and that some of the regional groups could combine into a larger group and eliminate the need of at least one of these conventions.

I also feel that each year the amount of time allotted to the program for lectures and meetings for the various associations has increased so that now even the sincere administrator or purchasing agent has to find time to rush through the convention hall. It is my feeling that if they need these lectures and meetings they should be done a day in advance of the convention and a day after and . . . shorten our exhibits to perhaps two days, but leave two days free for the hospital personnel to visit exhibits.

Use Trucks to Transport the Injured

Their size and availability make trucks a better choice than ambulances, taxis or buses for mass evacuation

LT. ROBERT McGRATH

TRUCKS rather than ambulances or buses offer the best means for transportation of the wounded in civil or war-time disaster involving mass casualties.

Organization of the trucking industry to assist in transportation of the injured is recommended especially because:

1. There are not enough ambulances in any community to carry more than a small fraction of the wounded in event of major disaster.

2. Buses may not be used to transport seriously injured litter cases unless the seats are removed or the buses are equipped to carry stretcher cases above the seat-back level. In serious disasters, too, buses may not be available in sufficient quantity to carry all the injured.

3. Trucks are available in most communities and the trucking industry is accustomed to organization for rapid transportation. Trucks may be used to carry litter cases without conversion and without added equipment. Large moving vans, especially, can carry up to 35 or 40 litter cases on the floor of the truck; with equipment to carry tiers of stretchers, these trucks could transport 100 or more cases at a time.

We proved these points about use of trucks for transportation of the injured in a demonstration last month at Mount Sinai Hospital, Chicago, where nurses evacuated a large number of patients quickly in a fire safety demonstration, loading these "casualties" into a moving van provided by a friendly truck operator. (See pictures.)

"Any time hospitals have to evacuate anyone, our trucks will be available —anywhere," said Joel S. Fishman, sales manager of the Hennepin Transportation Company, which provided a large moving van for the Mount Sinai demonstration.

The floor of the van provided space for 35 litter cases, lifted into the truck without difficulty by nurses, the demonstration proved. The Mount Sinai demonstration also included several other lessons aimed at teaching nurses and other hospital personnel a few little-known facts about fire safety technics. These were:

1. How to handle wastebasket fires in offices. Where there are no blankets or sheets available and the fire extinguisher may be some distance away, the fire can be smothered with a dust cloth, suit coat, magazine or even a sheet of newspaper (see picture).

2. Use of a nylon uniform to smother and extinguish a bed fire (see picture). There is a widespread notion that nylon is highly inflammable, unquestionably based on the fact that when nylon is rubbed against other material it builds up a charge of static electricity and is thus forbidden in the operating room and anesthesia induction area, where static electricity is hazardous. Nylon, however, is not more flammable than other materials and may be used to smother fires, just as blankets are.

3. Use of the CO_2 extinguisher to put out a gasoline fire (see picture). Until they have handled it themselves, nurses are frequently timid about the CO_2 extinguisher, so in our demonstrations we strive for repeated handling and use of the extinguisher by nurses taking part in the demonstrations.

The demonstration at Mount Sinai was a continuation of a program of training nurses in fire safety and evac-

Lt. McGrath is hospital inspector, Chicago Fire Department.

Patients may some day have to be removed from one hospital to another or to a remote safe area. In this event, trucks are the best means of transport.

In this picture, 35 patients are shown lying on heavy furniture pads covered with blankets on which they were carried out, covered with another blanket.

Removal by truck has the advantage that patients require minimum handling; also, patients and staff from one hospital can be kept together.

Betty Jansma, general staff nurse at Mount Sinai Hospital, Chicago, uses half of a discarded nylon uniform to show how to extinguish fire in a bed.

Hyman LeVine shows Dr. Stephen Manheimer (seated), Nathan Helman, and Jean Lo Buglio how to smother a wastebasket fire with a sheet of newspaper.

A student wields a CO_2 extinguisher for Chief James Collins, Commissioner A. J. Mullaney, Civil Defense Director Max M. Van Sandt, and the author.

uaction technics, now entering its second year. At the conclusion of the first year's program, during fire prevention week last fall, nurses from 16 hospitals took part in a demonstration of team evacuation technics at St. Luke's Hospital.

Nurses from the 16 hospitals brought their own equipment—blankets, CO_2 extinguishers, and soda acid extinguishers—to St. Luke's for the demonstration.

The teams from the several hospitals were so evenly matched that the judges, all fire safety authorities, had difficulty evaluating the performance. On the first day of the demonstration, the judges deliberated for an hour after the last team had performed.

In preparation for the demonstration, each team received about two hours' training at the home hospital and made one or two trips to St. Luke's for additional, on-the-scene practice.

During the demonstration, the teams worked on fire escapes—up to the 22d story of the hospital, and in the hospital's courtyard.

In the course of the demonstration, 32 nurses were required to extinguish gasoline fires with the CO_2 extinguisher. Not one failed. The wind was blowing in gale proportions, yet not one nurse miscued.

Following the demonstration, all the participating nurses were taken on a trip on the Chicago Fire Department's fireboat in the Chicago River (see picture on cover).

WINNING TEAMS IN THE FIRE SAFETY COMPETITION FOR CHICAGO NURSES

Above: Finalists in first group of nursing teams, front row: South Chicago Community Hospital, co-champions; rear rows (l. to r.): St. Luke's Hospital, Illinois Masonic Hospital, St. Bernard's Hospital. Below: Members of the first winning team (l. to r.) Marilyn Trumble, Mary Lu Kapturkiewicz, Barbara Williams, Judith Austin and Joan Czubernat present their award to Clara D. Schafer (center) administrator of South Chicago Community Hospital.

Above: Finalists in the second group of nursing teams, front row: Presbyterian Hospital, co-champions; rear rows (l. to r.): St. Elizabeth's Hospital, Mercy Hospital, Little Company of Mary Hospital. Below: Members of the second winning team (l. to r.) Jeanne Seeborg, Sally Ballinger, Virginia Granger and Mary Patterson present their award to Dr. Karl S. Klicka (far left), director of Presbyterian Hospital, and former chairman of the safety committee of the A.H.A.

Control Means More Than "Low Costs"

In its broadest and most appropriate sense, control of expenses in the nursing department goes in both directions: It is designed to prevent costs from going too high or too low

LOUIS BLOCK, Dr. P.H.

ANY discussion of controlling the costs of nursing care must be prefaced by an understanding of what is meant by controlling, and what is involved in nursing care. It is necessary to establish a common basis for understanding nursing service before methods of control can or should be undertaken.

The meaning of control is to regulate within limits or latitudes, to afford a standard of comparison, to test or to verify. Administratively, providing control requires being informed, interpreting trends, predicting results, and knowing when, where and how to institute remedial action in time. This is the key to the whole approach.

In order to have realistic controls, first there must be provided pertinent information, statistical and procedural, concerning the functions being performed and studied.

The purpose of controlling costs is to ensure equitable distribution of money spent for services rendered. This does not mean an equal distribution of funds by department, but rather one in proportion to the quantity and quality of services performed in relation to the market costs of such services.

Controlling expenses may, at first, give the meaning of keeping expenses down or reducing them. This is, however, a narrow interpretation of the term. In its broader and more appropriate sense, control goes in both directions. It prevents costs from going too high or too low. It is the latter interpretation of control that is directive to this discussion.

Nursing service is the largest of all hospital departments; it is influenced by and influences all other departments of the hospital. The operation of any one of the hospital departments is in some degree reflected in the effectiveness of each of the other departments. In practically all instances, hospital services are relayed or transferred to their recipient, the patient, through the nursing service. As such, the nursing department becomes a crossroads where all departmental administrative practices intersect or converge.

ESTABLISH ACCEPTABLE LEVEL

With specific reference to nursing service, a certain level of nursing care must be established and effected in the hospital. It is the responsibility of the hospital and the nursing department to make certain that the provision of nursing service does not go below this acceptable level, nor that it gets so far above this level that there is a waste of personnel and monies.

Just how do you control nursing costs? Before an adequate approach can be made to this subject, a look at the factors that affect nursing service costs is important. A baker's dozen of these factors are:

1. *The kinds of patients cared for, their length of stay, and the acuteness of their illness.* Most everyone will agree that these make for differences in nursing requirements. For example, in order to plan for proper assignments, it is necessary to have information regarding diagnosis of patients, and age of the patient. The total plan of nursing care will vary depending upon those related needs. Proper planning of nursing requirements based on such information will save nursing time.

2. *The size of the hospital and its occupancy.* The larger the hospital, the greater the departmentalization not only of hospital services themselves, but of nursing units, too. The size of the hospital determines supervision and distribution patterns of personnel. Effective assignment of personnel becomes an important factor with regard to best utilization of available competencies. Information on occupancy of the various nursing units becomes an important item of information from the administrative and supervisory point of view.

3. *The factor of minimum coverage must be reckoned with.* For that reason, there should be established a standard of nursing care below which it is unsafe for the hospital to operate. This should be done for each nursing unit, as well as for the whole hospital.

4. *The salaries paid to various types of nursing personnel.* Salary schedules

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Condensed from a paper presented at the annual meeting of the West Virginia Hospital Association, Huntington, W.Va., October 1955.

should be established with predetermined salary ranges, promotion scales, and increment policies.

5. *The length of the work week and work period.* Consideration should be given to the elimination of split shifts, which in turn does away with the establishment of premium salary payments for such hours of work.

6. *The extent of vacation and sick benefits.* This should be standardized and should be realistic. An established policy of vacation and sick benefits permits much better budget planning.

7. *The number of hours of bedside care available.* Precaution should be exercised that this information is accurate concerning care given and is not confused with care planned, or adulterated with hours other than those of bedside personnel.

8. *The proportion of nursing care that is provided by graduate nurses and by other than graduates.* This information is important in determining proper ratios of one group to the other.

9. *The utilization and assignment of nursing personnel according to competencies and preparation.* This requires job descriptions, job classifications, preemployment qualifications, and adequate supervision.

10. *The numbers of patients cared for,* nursing unit by nursing unit.

11. *The amount of centralized service provided,* such as central sterile supply, central oxygen service, postoperative recovery room, messenger and porter service.

12. *The physical layout of the hospital and the amount and kinds of equipment provided.*

13. *The presence of a school of nursing, or student nurses, and other educational programs.* The presence of a school of nursing always brings up the question as to whether or not it is a financial asset or liability to the hospital; this involves cost analysis.

The fact there are so many different factors affecting nursing service indicates that each hospital must be considered as a separate entity in planning for its nursing service needs. Most of the aforementioned factors involve three major areas that relate to expenses: personnel, supplies and equipment, and medical and administrative processes. Let us consider these three major areas as cost centers where controls can be instituted and carried out.

PERSONNEL

The first area, personnel, provides the greatest possibility of monetary savings in nursing service. What mechanisms of control can be established to control expenses of personnel?

1. *The total number of personnel providing nursing service.* An obvious method of controlling costs is to control the number of people working in a particular department or area. The mechanism of control that can do this job, and which exists in hospitals today, is the budget. Proper planning of the budget with regard to nursing service is important. The total number of employes, their distribution, their competencies and utilization are closely related but, nonetheless, are all factors adding up to total number employed.

2. *The ratio of graduate nurses to nonprofessional nursing personnel* is another mechanism that offers great possibilities to the control of expenses. Proper ratios should be established for each nursing unit, dependent upon services to be rendered and the number, kind and the condition of the patients being cared for in the different nursing units of the hospital. In order to accomplish this, information is needed concerning patient census and hours of nursing care by type of personnel providing such care. Such statistics are basic to the administration of nursing service. A great deal of help can be given to the nursing director by the business office in the establishment of the proper format for the collection of this information. In turn, the nursing service director must establish, control and clarify needs for personnel composition within limits of clinical safety.

3. *Adequate screening in the hiring of personnel* provides better qualified employes with the end result being a more efficient working staff. The result is better control of costs. In order to do screening, a job analysis must be done, written job descriptions and specifications must be established. This may well involve studies of functions and activities to determine definitely which activities should be performed by which people, with what types of preparation.

4. *Adequate inservice training and orientation of personnel* avoid waste of time and corrective measures, and do away with the need for repetitive instruction on a haphazard basis. The development of concise procedure books is helpful in this respect. Definite placement of responsibility for training is another essential.

5. *Good and understandable personnel policies,* the promotion of good working relationships and the provision of desirable working conditions in general reduce personnel turnover. These in themselves save many dollars to the hospital, and ultimately to the patient, too. Records of personnel turnover and the reasons therefor are essential mechanisms to this approach.

6. *An active and realistic health program* for employes pays dividends by reducing time off due to illness

FACTORS THAT AFFECT NURSING SERVICE COSTS

1. **Kinds of patients cared for**
2. **Size of the hospital and its occupancy**
3. **Minimum standard of nursing care**
4. **Salaries paid to various types of nursing personnel**
5. **Length of work week and work period**
6. **Extent of vacation and sick benefits**
7. **Number of hours of bedside care available**
8. **Proportion of care provided by graduate nurses and by other than graduates**
9. **Utilization of nursing personnel**
10. **Numbers of patients cared for**
11. **Amount of centralized service provided**
12. **Physical layout of hospital and equipment provided**
13. **Presence of a school of nursing; educational programs**

and accidents. A study of time loss and the contributing reasons would be helpful in instituting such a program.

7. *An adequate safety program for employes* also pays dividends. A study of the frequency of accidents, the kinds of accidents, and where they occur is needed to institute proper safety controls and programs.

SUPPLIES AND EQUIPMENT

The second major cost area, that of supplies and equipment, is one in which everyone considers himself an expert, and yet one which can exemplify cost controls more clearly than either of the other two areas. This is true because of the very tangibility—the materialness of the elements concerned. Some examples of mechanisms of control in this area are the following:

1. *The availability and maintenance of equipment and supplies* must be such that patients are not jeopardized or personnel inconvenienced. There must be enough materials, but they must also be kept in safe, usable condition. Cost is thus controlled through proper care and ready distribution to the place of need. This involves the management procedures of purchasing, storage, inventory, requisition systems and controls.

2. *A timesaving system in delivery of supplies is a medium of cost control.* This refers to the establishment of a method that does away with nursing personnel going after supplies every time they are needed. It requires the institution of a planned schedule of deliveries. Such a schedule must be based on information regarding the volume of materials required by the various nursing units. By materials, we refer to such things as syringes, trays, dressings and so on.

3. *The proper use and care of equipment* is an important medium of cost control. This means, in part, that records of repair and replacements should be maintained as a basis for determining proper usage and care.

4. *Labor saving devices* may represent initial expenditure, but in long-term efficiency and savings they usually more than pay their own way. This saving is realized primarily in relation to control of personnel costs and time. In order to determine the advantages of labor saving devices, special studies regarding personnel timesavings should be made. Examples of some labor saving devices are communication systems, syringe washers, glove washers, and medication carts.

5. *The method and procedures* used by nursing personnel can determine the amount and kind of materials needed. Likewise, obsolete equipment can force procedures to remain outdated and inefficient. Often a re-evaluation of such procedures or materials will disclose that some of them are in use simply because they have always been in use. We must not let ourselves lose sight of newer methods whenever they are indicated. In one situation a hospital was using a catheterization procedure requiring 13 cotton balls, no more and no less. It insisted that 12 were not enough and that 14 were too many. Yet, when the nursing staff analyzed the procedure, there was no scientific basis for specifically selecting 13 cotton balls. The result of this analysis was that the procedure was revised and streamlined so that four applicators replaced the 13 cotton balls, fewer utensils were required, and the whole procedure was so changed that there was a saving of 10 minutes per procedure. What is more, a safer method resulted.

6. *Many supplies of the same classification are used by several different departments and categories of personnel. They should be equitably and accurately charged* against such departments and not loosely lumped into, for example, the nursing department, and thus present a distorted picture of costs for that department. This specifically applies to those items which are normally considered medical and surgical supplies.

7. *Centralization of supplies* is another familiar example of control. It is a control of costs in that uniformity of charges, of procedures, of care and maintenance can be used, and uniformity of distribution and personnel functions are possible to establish. An example of such a situation is care of gloves. Unless the function is centralized and the procedure is standardized, experience has been that each nursing unit has its own procedure in the care of gloves. The result is that more and different kinds of equipment are being used, and it is much more difficult to check the validity and supervise the procedure being used.

8. *The provision of printed or duplicated forms* is a cost control measure to which we often do not give due recognition, especially in nursing. They are a control, first of all, through the saving of personnel time, and secondly, through the uniformity and accuracy which other substitute media do not ensure. The business office can offer real assistance to the nursing department in the proper development of these forms.

MEDICAL AND ADMINISTRATIVE

The third area of control is that of medical and administrative processes and practices. Because these are usually the controlling mechanisms themselves, most hospital authorities reasonably insist that they are the most important of the three. Some examples of these are:

1. *The established time of admission and discharge of patients* has a direct bearing upon costs of nursing service. An analysis of these procedures will indicate whether or not these procedures can be scheduled or controlled to prevent peak load periods from becoming heavier.

2. *The routine laboratory and related tests involve nursing personnel in the transmission of orders, the transportation of patients, and the adjustment of other procedures for the patient. This indicates the need for systematic scheduling of routine examinations,* in order to disrupt as little as possible other normal nursing activity.

3. *Medical care programs, medical practices and the load of physicians' orders* carry a tremendous impact upon nursing service. The pattern set by the medical staff determines total nurses required and the nursing care plans related to total patient needs. The frequency of changes in patient orders, methods and frequency of starting or discontinuing medications and treatments are examples of practices that determine number of nurses needed, volume and types of procedures to be carried out, staffing by periods of the day, and supervisory requirements. There is usually an ample source of records and reports as information for the study of these factors involving costs.

4. *Interdepartmental channels, placement of authority, delegation of functions,* and similar administrative controls have a direct bearing upon personnel time involved in exchange of services, in cooperative effort, and ultimately in cost. The use of routing procedures of interdepartmental communications and services should be sufficiently flexible to care for almost

(*Continued on Page* 136)

Reward of Good Planning: an Extra Floor

The addition to Herman Kiefer Hospital demonstrates the value of economical construction and modern materials

A. PAUL BENCKS

IN ITS few months of operation, Detroit's new and modern tuberculosis hospital addition at Herman Kiefer offers proof of two of the most important considerations in hospital expansion planning today:

1. The new in design can be added to the old and complement the complete facility both physically and functionally.

2. Economy of construction technics and the employment of modern materials through understanding architectural design can result in a facility equipped for an efficient program of treatment, care and rehabilitation and still incorporate the esthetic qualities so necessary for civic pride in a publicly owned institution.

Mr. Bencks is associated with H. E. Beyster & Associates, Inc., architects and engineers, Detroit.

At a cost of $1,940,000, Detroit has 252 additional hospital beds for its tuberculous population. This gives Herman Kiefer a total complement of 1200 beds with all of the services necessary to carry on an excellent program.

The per patient facility investment in the addition is approximately $7700 and includes a "bonus" in the form of an additional fifth floor which is completely roughed-in for 88 future patient beds, made possible through economical design—and the architect has framed for a future sixth floor, if the demand develops.

In a period of hospital construction history when the national averages per bed are running in the near $16,000 bracket, this addition to Herman Kiefer represents a real saving to the city of Detroit in both money and health. Monies for the hospital were granted by the state of Michigan, but the maintenance for the program is financed by the citizens of Detroit.*

When H. E. Beyster & Associates, Inc., of Detroit was named as architect-engineer for the project, a study of the function and goal of Herman Kiefer Hospital preceded the designing.

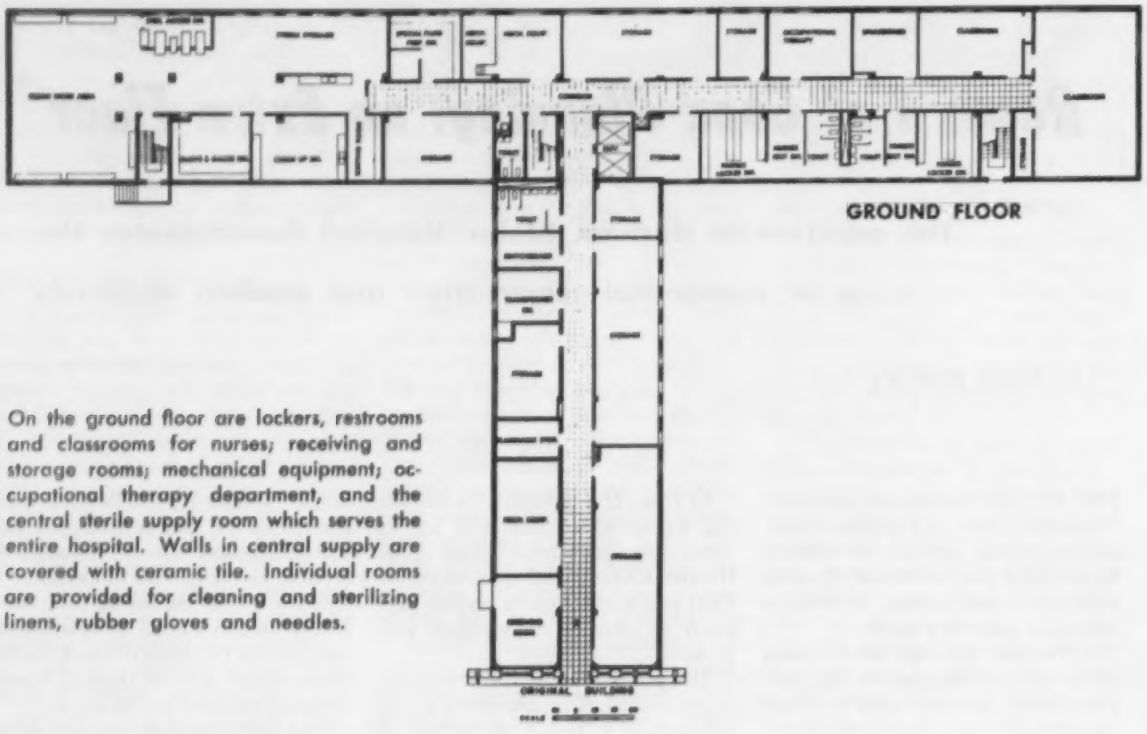
The entire program was accelerated by the cooperation of the client and the architectural firm, and planning sessions took place three and four times a week for two months in order to get the needed facility under way.

For several years, Detroit's TB program was inadequate because of the lack of necessary facilities. Recognizing this urgency, the officials of Her-

(*Text Continued on Page* 78)

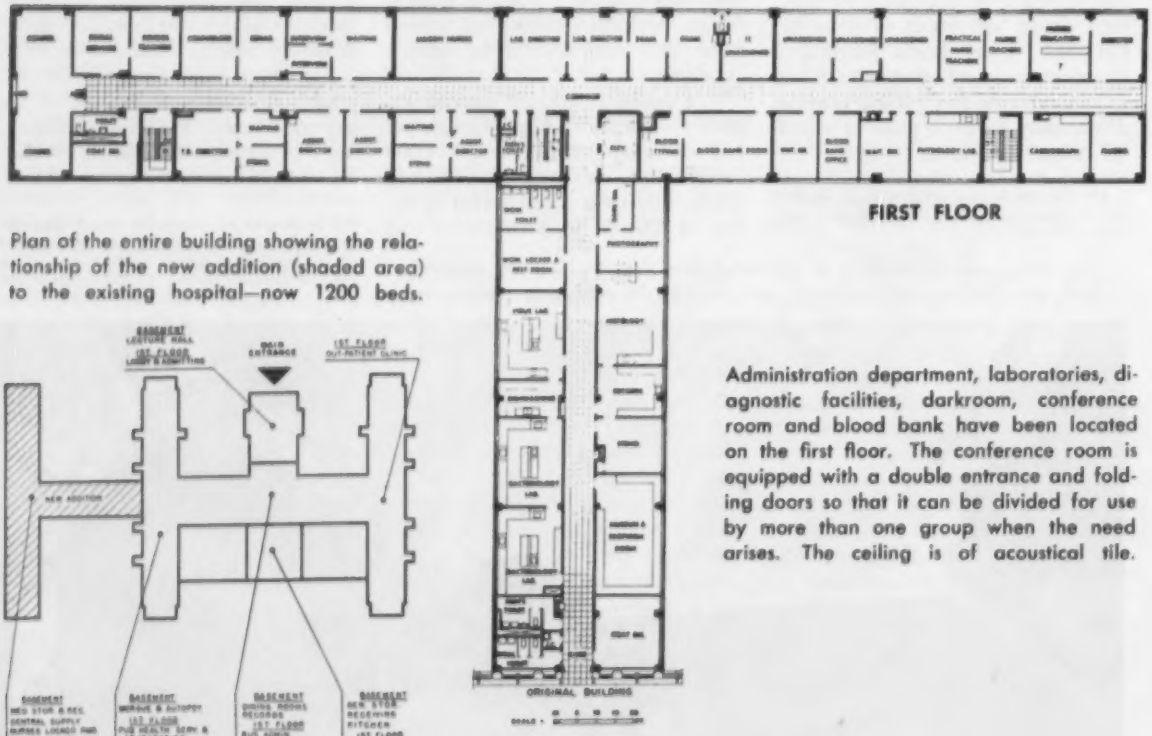
*It should be borne in mind that the national average would include power plant, laundry, kitchens and so on, which are not covered by this $7700 figure.—ED.

The new T-shaped addition to Herman Kiefer Hospital, Detroit, showing how new designs and materials can be tied in with older structures.



GROUND FLOOR

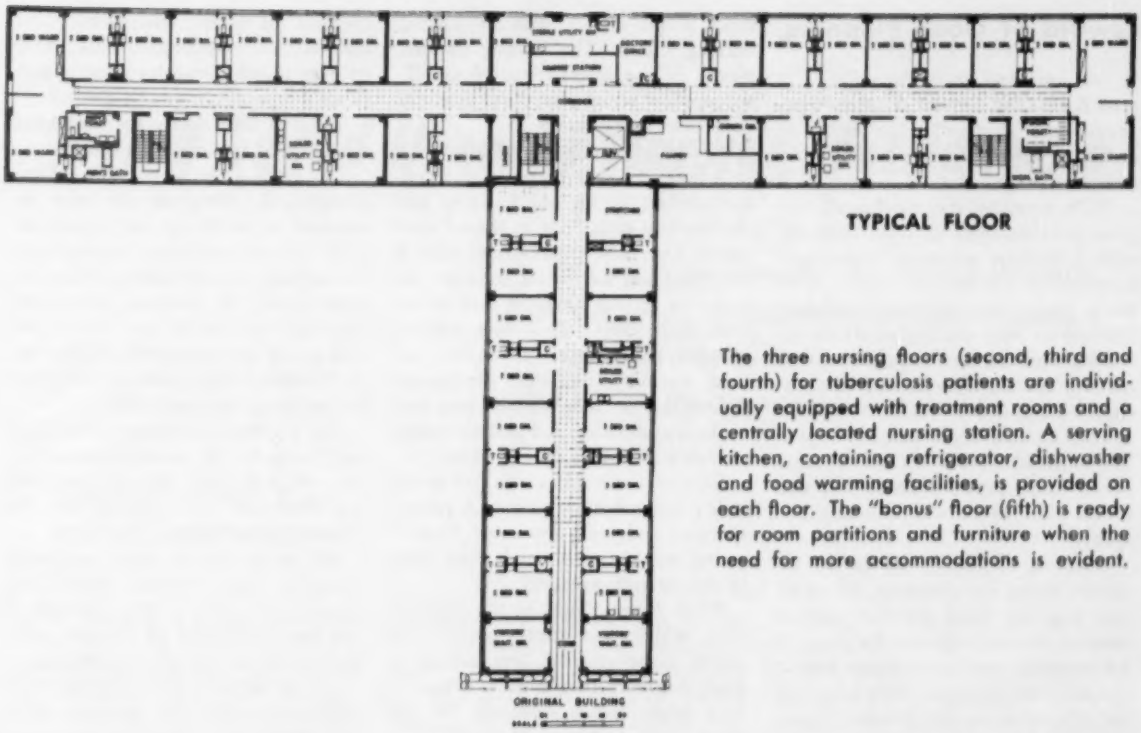
On the ground floor are lockers, restrooms and classrooms for nurses; receiving and storage rooms; mechanical equipment; occupational therapy department, and the central sterile supply room which serves the entire hospital. Walls in central supply are covered with ceramic tile. Individual rooms are provided for cleaning and sterilizing linens, rubber gloves and needles.



FIRST FLOOR

Plan of the entire building showing the relationship of the new addition (shaded area) to the existing hospital—now 1200 beds.

Administration department, laboratories, diagnostic facilities, darkroom, conference room and blood bank have been located on the first floor. The conference room is equipped with a double entrance and folding doors so that it can be divided for use by more than one group when the need arises. The ceiling is of acoustical tile.



TYPICAL FLOOR

The three nursing floors (second, third and fourth) for tuberculosis patients are individually equipped with treatment rooms and a centrally located nursing station. A serving kitchen, containing refrigerator, dishwasher and food warming facilities, is provided on each floor. The "bonus" floor (fifth) is ready for room partitions and furniture when the need for more accommodations is evident.

Two-bed room with built-in metal cabinets.

Nursing station located at intersection of the "T."

Individual processing rooms in central supply.

The autoclave area of the central supply room.

Reward of Good Planning

(*Continued From Page 75*)

man Kiefer and Beyster Associates expended the ultimate in an effort to make the new facility available within a shorter period of time.

With economy the watchword, the plan was developed in close harmony with a modular structural system and a correlated mechanical system. After basic plans were sketched, common dimensions were established which accommodated various arrangements of nursing rooms, laboratories, administrative areas, and so forth.

This module made possible repetitive construction technics and the reuse of job-built, plywood beam and slab forms. The result was economy and speed.

Selecting "flexibility" as the key for the designing and planning, the architect kept in mind the fact that as medical science progresses the program for treatment and care changes. Hence, the addition has been made adaptable for alteration in the future.

Folding doors were included along with movable metal partitions, particularly in the administration and professional instruction areas. Underfloor telephone and electrical services contribute to the goal of flexibility.

Everyone, including the doctor, the nurse, the patient, maintenance and nonprofessional personnel, was considered in the planning.

It took exactly 21 months for the planning and construction of the Herman Kiefer addition. The resultant structure was a T-shaped building of reinforced concrete. On the exterior, brick and masonry blended with the weathered brick of the original building, giving it an appearance of being new but strictly "in keeping."

Basement. Here is located central sterile supply (air conditioned) for the entire 1200 bed hospital. Also included on this floor are the linen, glove and needle rooms, the occupational therapy workshops, and nurses' training facilities, including flexible classrooms that may be expanded to lecture-hall size. Locker rooms, storage and mechanical equipment for the building are also located on this floor.

First Floor. Administration, laboratories, diagnostic facilities, darkroom, conference room, and blood bank facility have been installed on this floor.

Three Nursing Floors (2, 3, 4). The three nursing floors for TB patients are individually equipped with treatment rooms and a centrally located nursing station. The nursing stations, placed at the intersection of the T-shape, allow visual control of the entire floor from one point.

A serving kitchen is provided for each floor. Food is prepared in a central kitchen in the old building and delivered to each floor in heated food carts. The bulk distribution plan is employed, *i.e.* individual trays are set up in the serving kitchens, then served from food carts. This floor kitchen includes refrigerator, dishwasher and food warming facilities. Mechanical dishwashers in these pantries help prevent contamination and permit storage of dishes and silver on each floor.

Each of these floors also has sterile utility and subutility rooms. A pair of spacious and well appointed visitors' rooms are placed on each floor close to the elevator entrance.

Fifth Floor. This is the "bonus" floor which was made possible by astute planning. All serviced, it is ready for room partitions and furnishings when future demands call for more patient rooms. Presently it is being utilized by the hospital as a storage area.

Sixth Floor. A future possibility with all provisions made in original design to take care of this potential.

CONSTRUCTION COMMENTS

Technics which permitted the maximum of economy of the construction of Herman Kiefer Hospital addition included some of the following items:

1. Reinforced concrete frame with repeating structural bays in simplified framework were based on a 28 foot bay accommodating two bedrooms and a service core.
2. Flat slab floors, formed with plastic-coated plywood forms, make integral the ceiling and floor construction.
3. Ceilings are spackled and painted.
4. Repetition in floors allowed five reuses of the original forms.
5. Spandrel walls of Mankato limestone panels, backed with masonry.
6. Aluminum sash.
7. Extensive research and testing resulted in vinyl flooring for the laboratories, rubber tile in the nursing rooms and corridors, and asphalt tile for the office areas.
8. Suspended acoustical ceiling in the corridors conceals mechanical and electrical runs and prevents sound transmission. In the corridors this acoustical tile is glass fiber with an overcoat of plastic membrane. This material has a decorative effect with its over-all color-on-color pattern, and, being nonporous, it can be cleaned.
9. Underfloor electric and telephone ducts in the administrative areas.
10. Flush panel doors with plastic surface and honeycomb core offer the ultimate in durability and cleanliness.
11. Central television antenna with connections to each room provides entertainment for patients and keeps them in touch with the world from which they are temporarily withdrawn. At Herman Kiefer, these sets are given by service groups and clubs.
12. Lighting is recessed in ceilings and walls. In the patient rooms, there are two-way wall fixtures, switched for individual bed lighting and for general illumination.
13. Steam for the entire hospital is furnished from a central plant at 50 pounds per square inch, reduced in the mechanical core of the new addition to 15 p.s.i. for general heating.
14. A two-way audio-visual system allows communication between nurse and patient and results in timesaving for the nurse and a good psychological reaction from the patient .
15. Parking area, completely paved, for 140 cars was provided as part of the total contractural price.

Recognizing the therapeutic value of color, the architect used this warm and friendly ally in every patient's room and even in the laboratories and the administrative office.

HOMELIKE ATMOSPHERE SOUGHT

Because of the nature of their disease TB patients must be confined in a hospital for a longer period of time than other types of patients are and the architect wished to achieve as nearly homelike an atmosphere as possible. For the rooms on the cool side of the building, warm yellow colors were selected and for the side where there is an abundance of sunlight, blue was employed.

Following the trend in modern hospitals toward more built-ins, the architects used this technic in the patients' rooms. Built-in dressers, cabinets, wardrobe closets, and even a recessed and individual wash basin, release the maximum of floor area. Recesses were provided for TV cabinets (serviced by a central TV antenna system). Ceramic tile wainscoting frames the wash basin and this, too, is in a harmonizing hue. Floor tiles are in colors to blend with the room's décor.

Flying Squad Uncorks Nursing Bottlenecks

It's not a panacea for the nursing shortage, but this group of intensively trained attendants at least relieves the nursing department of routine duties, thus improving everybody's morale

DOROTHY REHM, R.N.
HARVEY MACHAVER

THE shortage of professional nurses has become a challenging force to most hospitals. In an attempt to solve this problem, Montefiore Hospital, New York City, has employed many methods including practical nurse training, aide training, and certain professional recruitment devices. These were helpful but not completely successful.

The effects of the shortage on our staff nurses became apparent. Many complained of being tired and dissatisfied at the end of their day's work. They felt that they spent their time trying to catch up with things undone instead of providing a satisfactory standard of patient care. Two major manifestations of this feeling were expressed by the nursing staff. The first was friction with other departments and members of the house staff; the second, increased absenteeism. The latter intensified the shortage of staff, thus increasing the work load on those who would report for duty.

AT LEAST ONE FLOOR SHORT

Staffing reports for the day shift were reviewed. They indicated that on any given day there was at least one floor critically short of manpower. There were usually two such units but never more than three.

Head nurse meetings were held to study the problem. It was found that morning care, including bed baths, bed making, and general patient care, stretched well into the day because staff members were busy performing duties which included medications and treatments. If they could be assisted through peak periods of activity early in the day, they could then manage effectively for the remainder of the shift.

An obvious solution to meet these emergent situations seemed to be the utilization of float personnel. This is not a new concept and has been used in many hospitals. Montefiore had tried this method but had found it unsatisfactory. Some of the reasons for the failure of this approach included:

1. The floor nurse was required to spend a great deal of time in the orientation of the float personnel. Unless the particular person had been on the unit recently, the head nurse felt that it would be easier to try to struggle through.

2. The head nurse had to spend so much time in close supervision and follow-up that it counteracted the advantage of having the additional personnel.

3. Head nurses and staff nurses resented changes in planning resulting from float staff off their usually assigned floor.

4. The person who was reassigned objected, stating: (a) "I don't like to float"; (b) "the regular staff takes advantage and gives me the worst assignments to do"; (c) "this floor does not need any more help than the floor I'd like to go to."

5. Float personnel was unfamiliar with patients and other staff members.

6. Float personnel did not feel appreciated or accepted and often felt resented.

7. Float nurses stated that they were not oriented or instructed but were expected to perform on a maximal level.

REQUIREMENTS FOR SOLUTION

An equitable solution involving the utilization of float personnel had to include the following characteristics:

1. The head nurse would not be required to orient and instruct floor personnel.

2. The head nurse would not be required to do close supervision and immediate follow-up of work done by float personnel.

3. The tasks performed would have to be sufficiently time consuming so that the presence of float personnel would be of significant help to the floor.

4. The type of assignment performed by float personnel would have to be limited so that the group could be trained to perform a limited number of tasks efficiently.

5. The floating group could not be composed of staff nurses since floors with shortages would demand permanent assignment of any R.N.'s who were employed.

6. Float personnel would have to be made members of a cohesive group and would have to function as a group, drawing approval and strength from one another.

We decided to establish a "flying squad" of nurse's aides and attendants, trained to work as a group and oriented as float personnel to the entire

The authors are respectively educational coordinator of the nursing department and assistant director, Montefiore Hospital, New York City.

hospital. The area of responsibility of the group was established by selecting those duties which could be done without extensive orientation and instruction being given by the head nurse about specific needs and status. It was decided that making empty beds, feeding patients, giving baths, helping patients out of bed, and other such uncomplicated procedures could be managed effectively.

It was agreed that the group would function only as a group throughout the morning hours. No one member of the group would be detached to relieve a single shortage in a given unit. It was decided that members of this group could be trained to carry special assignments in the afternoon which had previously been performed by unit personnel. Such special assignments include work with orthopedic and oxygen equipment, assisting in special clinics, working with central messenger service, and staying with patients who need constant but nontechnical observation.

The entire plan was reviewed with supervisory and head nurse groups. The duties and limitations of the experimental flying squad were discussed and a trial period was agreed upon.

SELECT FOUR ATTENDANTS

Four attendants were selected to participate in the experiment. It was felt that a larger group would be unwieldy and present supervisory problems. A smaller group did not seem feasible because it could not accomplish enough. Two men and two women were selected on the following basis:

1. The previous employment records showed regular attendance and a good work history.

2. The employe had demonstrated definite interest in patient care.

3. The employe had demonstrated above average intelligence in his previous work experience.

4. He had shown ability to work smoothly and rapidly without becoming easily upset by pressure.

The members of this group were made to feel the importance of the job they were to undertake, the reasons it was a good plan, and how they could help to make it work. The working hours from 8 to 4:30 p.m. were established even though the hospital staff was on a 7 to 3:30 p.m. shift. It was felt that the hour difference would enable the floor nurses to evaluate their needs for the day and also allow time for calls of illness or absence to arrive in the office.

Training of the group extended beyond the one week (40 hour) period established for the regular attendant staff. Approximately three weeks were afforded to this program—one week in class and then practical experience, closely supervised.

The first day was spent in orientation to the hospital philosophy and physical setup. The second day was spent in discussion of patient reaction to illness, special problems which might be encountered, and possible reactions of the patient to this type of care. Special consideration was given to the attitude of members of the group toward patients in their care during these short periods. Consideration was also given to observations the group was expected to make and the method of reporting findings to charge nurses. The remainder of the week was spent reviewing procedures, supervising return demonstrations of these procedures, and in a question and answer period.

The first day of the second week, the group with the instructor spent 20 minutes in reviewing and planning. Under the supervision of the instructor, the group reported to its first unit. Orientation as to location of equipment, types of patients on the unit, and patients to be cared for was given the group by the instructor. This relieved the head nurse of both induction and supervisory responsibilities. The head nurse gave to the instructor a list of 12 patients whose morning care would be carried out by the flying squad. These patients could be out of bed after a bath, none was acutely ill, and only a few had to be fed. Baths were given and beds were made and the assignment completed at 10:20 a.m. Since another unit also requested the help of the group, it proceeded to the new location. The instructor again assumed the responsibility for orientation. The group finished this assignment of 14 patients by 12 noon, and reported off for lunch. In the afternoon the group was broken up and given special assignments. The men went to messenger and oxygen service; the women to units where additional staff was needed.

The head nurses on the floors to which the squad was sent stated that the group was particularly effective because assignments were uninterrupted. Furthermore, the floor nurses, with this significant work load removed from their schedules, were able to complete morning duties before the lunch period.

From the patients we learned that they enjoyed having beds made and their baths given early in the day. The flying squad itself was friendly and showed initiative in carrying out assignments. The squad members needed considerable practice in procedures but generally did well.

In the days following, the group developed speed and competence. The instructor acted as an on-the-spot resource person orienting the group to each new floor and providing technical instruction where needed. It was found that the list of responsibilities of the group could be expanded but that the group would lose its effectiveness if its duties became too widespread.

SUPERVISION DECREASED

As the experiment progressed, we realized that the constant supervision of the instructor could be decreased greatly. The squad was stabilized and satisfied with its responsibilities. The members wanted to make the experiment work. The instructor was called upon only when a new procedure was introduced or to act as coordinator when the group was assigned to a new unit. At no time was a head nurse required to orient the group or spend any time with it in direct supervision.

Members of the flying squad agreed to rotate leadership among themselves. Each day the elected group leader reported to the nursing office for assignments and to make reports. The instructor continued to be available whenever problems arose and periodically checked group performance.

A number of follow-up evaluation meetings were held with floor personnel. The results were satisfying. Professional nurses commented that the flying squad was extremely helpful. The knowledge that the group was available allowed for better planning and made for less confusion on the nursing unit. One staff nurse stated that having the group for one hour in the morning when activity on the unit was at its peak was better than six hours of help at any other time.

Practical nurses were similarly enthusiastic about the project. They said that their work load was lessened and more time was at their disposal to take care of details which otherwise would have been omitted.

The morale of the flying squad was excellent. These employes were willing

and anxious to do a good job as quickly as possible. They were made to feel that they were helping the unit staff. Floor personnel often expressed appreciation for the work accomplished.

The flying squad is a cohesive work group. Members work together and accept assignments cheerfully. They feel that as a group they "belong" to each other as well as to the unit to which they are assigned. They do not have to search for equipment, wonder about the kind of patients they will be given, fear the reception they may receive, or expect the worst assignments. These matters were established early in the program and they work under a well defined set of duties.

On the basis of a review of the effectiveness of this program, it was decided to keep the flying squad as a permanent part of the nursing service department. There were many reasons for this decision. Absenteeism decreased both in comparison to the time immediately prior to the inception of the program and in relation to the same period during the previous year. Friction between nursing staff and other departments, including house staff, was greatly reduced. Morale of the nursing department seemed to increase as a result of the group's efforts. Floor nurses stated: "The nursing office does not just acknowledge the fact that we need help, it does something about it." Calls for help into the nursing office decreased significantly. In fact, units have recently called the nursing office when they felt that they had personnel time to share. The problems —so evident when constant floating by individual staff members was necessary —have decreased. Squad members have enjoyed their rôle as float personnel and have had little illness or absence.

The flying squad has problems of its own but these are relatively small in relation to the job which it accomplishes. The fact that it holds a unique place in the department has given it a great deal of prestige. The group has been satisfied and stable, refusing permanent assignments to floor units.

We have learned a number of lessons from this program:

1. The feeling of belonging is important in employe satisfaction but this feeling is related to a social group rather than a location, such as a specific nursing unit.

2. If a nursing unit, no matter how short of personnel, can get over the hump of heavy routine duties early in the morning, the rest of the day's work can be accomplished to the satisfaction of floor personnel.

3. The knowledge that help is available does not necessarily lead to abuse. In fact it leads to a willingness to share rather than to hoard personnel time.

In actuality the number of man-hours provided by the flying squad fell far short of the number of openings for professional nurses which existed in the hospital. The flying squad did not, on a permanent basis, eliminate the need for a large number of additional nurses. In essence, the squad became a symbol to floor nurses that the nursing administration was sufficiently interested in their needs to attempt new ways of helping.

The prior acknowledgment and sympathy of the nursing office was of no help. The program, even though token, was, as a morale builder, extremely successful.

Staff and Board of Renton Hospital Agree to Arbitrate Future Conflicts

RENTON, WASH.—A bitter controversy over whether the medical staff or the governing board controls membership on the staff of the publicly owned Renton Hospital has ended with agreement on a sort of arbitration in the event of future conflicts of views.

The machinery provided for in the agreement has yet to be tested.

Meanwhile, the staff is exercising the self-government it sought to protect. The board continues to hold the final authority its members always maintained were granted them by law. And the one doctor whom the board sought to oust from the staff 14 months ago still is a member—but on a basis that he can perform no pelvic or major surgery for 18 months without approval of a consulting physician, preferably one not on the staff.

The truce resulting from out-of-court settlement of litigation between the staff and the board was not entirely an easy one as the staff met for its annual election of officers and executive committee members last month (January).

Should the board at a February meeting withhold approval of any of those elected, the dispute settling procedure of the agreement might be given its first test.

Then a third party, the King County Medical Society (Seattle), would be called in to investigate and recommend a settlement to the board. The medical society will act similarly in event of disagreement on appointment of new staff members, reappointments or removal of doctors from the staff.

Spokesmen for both sides of the dispute agree that the settlement was a compromise that is less satisfactory than a judicial ruling would have been.

It is the board—the three elected members of the Board of Commissioners of Public Hospital District No. 1 —which is least happy with the settlement.

"This is a very unsatisfactory solution, a rank miscarriage," J. M. Clarke, commissioner and board secretary, said. "On its face the agreement purports to maintain authority in the board. But actually our hands are so tied up in red tape that our power is reduced to nothing."

Mr. Clarke said he now believes the board should have "insisted" on a court ruling, but instead beat "a shameful retreat" after becoming convinced it could not win before a judge, because it has been "deserted by our professional advisers and some of our medical witnesses who had promised to help us."

Dr. J. D. Hogan, chief of staff, and one of the 25 staff members who brought suit against the board, said "many on the medical staff would have preferred a court ruling. At the time of filing we felt we owed it to the community and the profession to have the matter of authority interpreted.

"But we came to see that no court decision could be final on the broader issues. It is a difficult thing in any hospital to draw the line between medical and administrative matters. It is difficult to administer, if such a line can be drawn.

"In our own case, we have the issue of lay experience opposed to medical experience in hospital management. We did not think that a board of three laymen, elected on a staggered

(*Continued on Page* 160)

Teachers Get a Lesson in Hospital Work

A workshop for high school teachers and vocational counselors made friends for Dallas hospitals and laid the groundwork for future recruitment of employes

MARJORIE SAUNDERS

THE public relations committee of the Dallas Hospital Council sponsored a workshop for vocational counselors and homeroom teachers at Parkland Memorial Hospital in Dallas, Tex., last November.

The workshop was the culmination of a series of meetings and extensive planning on the part of the committee. For several years, individual members of the public relations committee had attempted to interest the Dallas school board in a workshop of some type for teachers and counselors in order to acquaint them better with hospitals generally and with the career opportunities therein. All of the efforts had been unsuccessful.

After the formation of the public relations committee of the Dallas Hospital Council, one of the early projects of the group was to invite the superintendent of Dallas public schools, Dr. W. T. White, to a regular luncheon meeting of the committee. A representative of the Dallas Catholic high schools was also invited to the luncheon. At that time, it was explained to Dr. White that Dallas hospitals were interested in providing helpful information to vocational counselors in the junior and senior high schools so that counselors could provide students with

The author is director of public relations, Baylor University Hospital, Dallas, and chairman, public relations committee, Dallas Hospital Council.

Teachers and counselors tour Parkland Memorial Hospital during the workshop to see what hospital workers do and how they go about it.

The five-minute presentations held the interest of the audience. Subjects covered included both the administrative and the technical specialties.

more authentic information regarding hospital careers. Dr. White suggested that the public relations committee meet with a group of these counselors, and a meeting was scheduled at the school administration building to which members of the committee were invited.

At that session, each member of the committee explained the purpose of the meeting to the counselors present. The counselors, in turn, suggested that homeroom teachers were also vitally concerned with counseling and should be included in any future plans. It was further suggested by the counselors that the public relations committee provide them with one piece of literature or one booklet to which they could refer for information. The booklet should list, in brief, the qualifications for the various vocations and professions offered in hospitals.

The committee members agreed to provide the material in question and also asked the counselors if they would be interested in attending a workshop for this purpose. The majority of the group present thought a workshop would be helpful but suggested that it be held during one of the fall months.

Immediately following this joint meeting the public relations committee began preparation for a workshop to be held in the fall. Several meetings of the group were held to formulate the program to be presented. Plans were finally completed and a letter of invitation was sent to the school administration building and, from there, was distributed to the various junior and senior high schools. The same letter was also sent Catholic high schools. A return registration blank was enclosed. Both the letter and the registration blank are quoted here.

YOU ARE CORDIALLY INVITED . . . TO ATTEND A WORKSHOP FOR HOMEROOM TEACHERS AND COUNSELORS
of our Dallas Junior and Senior High Schools, conducted by the Dallas Hospital Council.
Date: Saturday, November 5th
Place: Parkland Memorial Hospital
5201 Harry Hines Blvd.
Time: 9:00 a.m.-3:00 p.m.

"The Workshop is being planned for you because it is the belief of the Dallas Hospital Council that first-hand knowledge of vocational and career opportunities in the hospital field would be helpful to you in counseling students. The need for qualified persons, both vocational and professional, in this vital field is great. Furthermore, shortages of qualified staff members and personnel in hospitals vitally affect citizens of every community.

"We believe the program planned for you will be informative, interesting and satisfying. The sessions will be led by people who know their subjects. You are to be our guests for lunch and will also be given a guided tour of the new Parkland Memorial Hospital to see firsthand how professional and vocational members of the hospital staff actually function.

"Please fill out and return the attached slip to the person designated in your school so that we may complete our plans and arrange a luncheon plate for you.

"We are looking forward to the pleasure of meeting you on November 5th."

Both administrative and specialized careers were discussed during the day-long session. These included:

ADMINISTRATIVE

- Hospital business manager
- Medical secretary
- Medical records librarian
- Personnel relations
- Admitting clerk
- Public relations

SPECIALTIES

- Medical technology
- X-ray technology
- Physical therapy
- Occupational therapy
- Electrocardiography, encephalography and basal metabolism
- Anesthesiology
- Dietary
- Engineering
- Pharmacy
- Nursing

We realized that it would be impossible to cover all vocations and professions so a decision had to be made to choose only a portion of the

professions and some of the specialties. Each speaker was given approximately five minutes in which to make his presentation. A question and answer period followed each presentation. The five-minute presentations were well received. There was also good participation in the question and answer period. Following the morning session, a tour of the hospital was given to the registrants.

Following the tour, a résumé and evaluation of the workshop was given by Rod Bell, president of the hospital council. Evaluation sheets were distributed during that period and frank comments were solicited.

Quotes from some of the evaluation sheets, which were typical, are listed below:

"An excellent and efficient idea, which will be productive of better counseling and better service to the community."

"This is a very worth-while contribution. Thanks a million."

"It was an excellent workshop. More Dallas teachers should take advantage of this highly educational opportunity."

"An informative meeting—enlightening as well as enjoyable. A day well spent."

"Well organized, very educational, interesting to see and hear from people in the professions discussed."

"It has been informative and enjoyable."

"Workshop planning, program and presentation very well done. Appeared to establish a group rapport and consequent better understanding of personnel relationships between areas of the school-hospital."

"This is a step in the right direction."

"Not a 'put-up' deal; shows sign of genuine need, and we need you also. Thanks."

"The hospital is so efficiently designed that our tour was a real pleasure."

"It has been most helpful to me as a vocational teacher in part-time cooperative training."

"More teachers should know about the program."

"I found the discussions most interesting and informative. I enjoyed the tour through this wonderful hospital. Career opportunities for students are manifold. I hope we can make our young people aware of them."

"I can certainly urge other teachers to attend a similar workshop."

"The workshop was very enjoyable and informative."

"The program was well handled and evidenced expert planning. It was most beneficial to counselors."

"The workshop was well organized and very interesting."

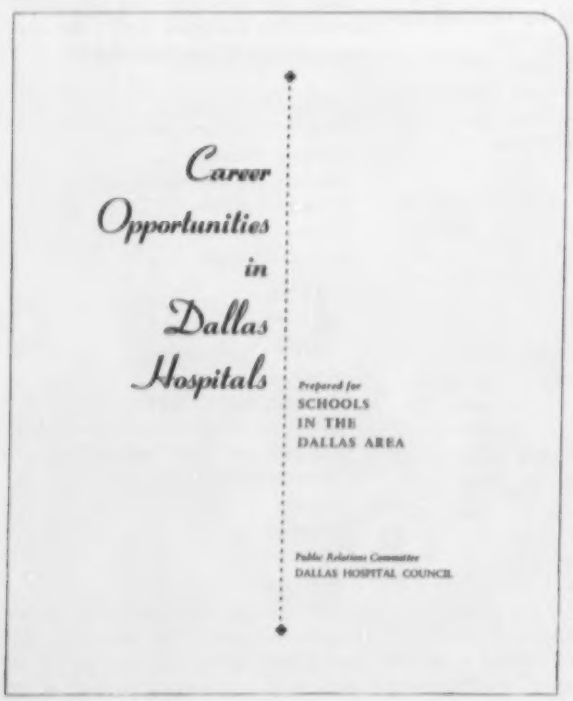
"Now my knowledge and concern for these various deeply worth-while occupations have been increased greatly."

"This is surely a generous service you have rendered to us. We are more grateful than words could ever express for the tremendous effort and man-hour planning that went into the success of this program. It was one of the most beneficial experiences, both interesting and educational, that I have been privileged to enjoy."

A portfolio containing complete information on, and listing requirements of, various positions and professions in a hospital was prepared. It also included national literature on the various subjects discussed. Samples of this portfolio were displayed at the meeting. Two hundred copies were furnished the school board for distribution to junior and senior high schools for use by the homeroom teachers and counselors. These portfolios were well received and virtually all of the counselors indicated an immediate desire to have one available for their use.

Although the workshop was held immediately following the state fair and during the football season, there was a good representative attendance. The interest of the group was encouraging. All the registrants expressed great appreciation for the opportunity to attend such a workshop and indicated that they felt efforts of the public relations group constituted a distinct and advantageous contribution to the school system. All of them expressed the wish that every homeroom teacher and counselor could attend such a session. They further stated that they felt much better informed concerning the information presented and they had no idea that the hospital field offered such a variety of opportunities. Many of the teachers in the vocational high schools could see tremendous advantage in presenting the hospital picture to students who would be unable to pursue a college career but would like a dignified and interesting position.

The workshop is to be used as a pattern for a similar program on a statewide basis. In a meeting of the public relations committee for the purpose of evaluating the workshop, each member expressed the view that although a second workshop could be vastly improved, the efforts that had already been made were certainly worth while.



Cover of the portfolio furnished for distribution to homeroom teachers and counselors of Dallas junior and senior high schools to help students select their vocations.

ABOUT PEOPLE

Administrators

Leo Lyons, chief administrative officer of St. Luke's Hospital, Chicago, for the last 14 years, is retiring March 31. Mr. Lyons is a past president of the Chicago Hospital Council, the Illinois Hospital Association, and the American

Leo Lyons

Joseph P. Greer

Protestant Hospital Assembly. He is a member of the American College of Hospital Administrators. **Joseph P. Greer,** now assistant director at St. Luke's, will become director April 1. Mr. Greer was formerly assistant administrator at the University of North Carolina Hospital, Chapel Hill. He is a graduate of the University of Chicago course in hospital administration.

Richard Highsmith is the new administrator of Samuel Merritt Hospital, Oakland, Calif. He succeeds **Ellard L. Slack,** administrator since 1928, who has retired. Mr. Highsmith has been associated with Children's Hospital of the East Bay, Oakland, as executive vice president. Foremerly he was director of the Oak Ridge Hospital, Oak Ridge, Tenn., and has been assistant director of the Evanston Hospital, Evanston, Ill. Mr. Highsmith is a graduate of the University of Chicago course in hospital administration.

Richard Highsmith

Edward W. Gilgan has been appointed director of Hurley Hospital, Flint, Mich. Mr. Gilgan, who has been assistant director at the hospital since 1954, will succeed **Ralph C. Hutchins,** who is now administrator of the Alma Hospital, Alma, Mich. Before going to Hurley, Mr. Gilgan served as director of Ryburn Memorial Hospital, Ottawa, Ill., and previously was administrative assistant at St. Luke's Hospital, New York. During World War II, he served in the medical administration corps of the U. S. Army Air Force on the general medical staff in London. Mr. Gilgan is a graduate of Northwestern University's course in hospital administration and has been a member of the staff of the school since 1950. He is a member of the American College of Hospital Administrators.

Edward W. Gilgan

John E. Millizen, administrator of the University of Illinois Research and Educational Hospitals in Chicago, has retired after serving the university for 33 years. Mr. Millizen assumed the duties of administrator of the hospitals in 1945. He is a member of the American College of Hospital Administrators and has served on the Council on Administrative Practice of the Illinois Hospital Association.

Herbert Abramson and **Martin Saren** have been appointed assistant directors of the Long Island Jewish Hospital, New York City. Mr. Abramson was formerly assistant director at Mount Zion Hospital, San Francisco. He has also served as administrative assistant at Knickerbocker Hospital and administrative resident at Beth Israel Hospital, both in New York City. Mr. Abramson holds an M.S. degree in hospital administration from Northwestern University, and is a member of the American College of Hospital Administrators. Mr. Saren, prior to his appointment, was assistant director of Grasslands Hospital in Valhalla, N.Y. He holds an M.S. degree in hospital administration from the University of Minnesota and is a member of the American College of Hospital Administrators.

Bertram G. Hanson has been appointed administrator of Memorial Hospital, McHenry County, Woodstock, Ill. Mr. Hanson was formerly assistant administrator of Children's Memorial Hospital, Chicago, and was for three years purchasing agent of Augustana Hospital, Chicago. He is a graduate of the University of Chicago course in hospital administration and a nominee of the American College of Hospital Administrators.

B. G. Hanson

James H. Moss has been named director of Riverside Hospital, Toledo, Ohio. Prior to this appointment, Mr. Moss was administrator of Audrain Hospital, Mexico, Mo. He is a graduate of Northwestern University course in hospital administration.

(*Continued on Page* 170)

DR. WILMAR M. ALLEN AND DICK L. BRASKAMP DIE

Dr. Wilmar M. Allen, director of Hartford Hospital, Hartford, Conn., for 17 years before his retirement in January 1954, died in Chapel Hill, N.C., January 14 at the age of 61. Dr. Allen joined the staff of Hartford Hospital as pathologist and bacteriologist in 1925 and was named director of the hospital in 1936. Widely known for his activities in the hospital and medical fields, he served as president of the American College of Hospital Administrators and of the New England Hospital Assembly, and served on various councils and committees of the American Hospital Association.

Dr. W. M. Allen

Following his retirement from Hartford, Dr. Allen spent a year as consultant to the hospitals of Belgium under a Fulbright grant. He returned to the United States last November.

Dick L. Braskamp, administrator of Alhambra Community Hospital, Alhambra, Calif., for more than 21 years, died December 18 after a short illness. He was 62 years of age. Mr. Braskamp was a past president of the Association of Western Hospitals, the California Hospital Association, and the Hospital Council of Southern California, of which he was a director at the time of his death.

Dick L. Braskamp

What About Future Hospital Construction?

After a brief review of gains already made in hospital construction, the author points to some of the unmet needs and asks questions that will have to be answered before these needs can be met

JOHN W. CRONIN, M.D.

TODAY our hospitals are tangible symbols of our feelings toward one another and our expressed ability to provide facilities for the care of the sick and injured. The modern hospital is no longer the springboard to eternity. It has become the true health center of the community. The term "hospital" represents the place where curative medical practices are being fused with those of preventive medicine to provide and promote health maintenance programs.

In our nation today, according to Ray E. Brown, president of the American Hospital Association, 50 per cent of our hospitals are over 50 years of age. The average life expectancy of a hospital is 50 years. A compilation made from the respective state plans required by the Hospital Survey and Construction (Hill-Burton) Program reveals a national deficit of more than 800,000 beds in all categories—general, mental, tuberculosis and chronic.

Under the Hill-Burton program, which was instituted in 1946, 2600 projects representing 120,000 hospital beds, 550 public health centers, and a number of related health facilities have been approved. In this federal, state and local community endeavor, more than $700 million has been matched with $1.3 billion of sponsors' funds.

Dr. Cronin is chief, Division of Hospital and Medical Facilities, Public Health Service, Department of Health, Education and Welfare, Washington, D.C.

Presented to the Mississippi Hospital Association, Biloxi, Miss., October 1955.

In Mississippi 92 projects have been approved for a total cost of nearly $39 million, of which the sponsors' funds represent about $20 million. When the projects are completed a total of 3192 beds will have been added. Of these beds, 2778 are general, 154 are tuberculosis, and 260 are mental. In addition, 37 public health centers have been approved. The largest project is the University of Mississippi Medical School Hospital. This institution will train urgently needed health workers for all parts of the state.

According to the 1956 revision of the Mississippi state plan, submitted by the Mississippi State Commission on Hospital Care, there remains a need for 4047 general hospital, 347 tuberculosis hospital, 6967 mental hospital, 4360 chronic disease hospital, and 1830 nursing home beds.

WHAT HAS BEEN DONE

Much has been done in Mississippi and throughout the nation. The Hill-Burton program represents 34 per cent of all the hospital construction taking place. Approximately $600 million is being spent annually from all sources of funds for the construction of hospitals. Yet, we have only just kept pace with those two ever present factors—population increase and obsolescence (physical and functional) of our facilities. We have not made any appreciable inroads into the 900,000 bed deficit which existed in 1947, having accumulated over 10 years of economic depression followed by the years of World War II.

Despite the fact that there has not been a net increase in bed numbers, we have made great gains. At present we have:

1. Established an orderly nationwide system of hospital and related health facility construction.
2. Improved the design of health facilities with emphasis upon function.
3. Assisted communities to acquire physicians and nurses, especially in the rural areas.
4. Stimulated action for, and acquired, needed new hospital licensure laws in most states.
5. Created an awareness of the value of positive programs of health maintenance.
6. Achieved a recognition of the rôle of hospitals and health facilities in the national economic and total security.

Patrick Henry said: "I know no way of judging the future but by the past." We have just taken a glimpse of that which is past. Let us now consider the future through the minute peephole which we, in the present, are too likely to regard as great windows. Let us try to replace our pipelike vision, which is narrow, with that of the funnel type, which helps to broaden our view.

The trend of medical practice is moving rapidly toward the treatment of the ambulant individual. Diagnostic and therapeutic aids and instruments of precision are being developed and

utilized as our technical knowledge and skills increase.

Health care today requires facilities for prevention, diagnosis, treatment, extended care and rehabilitation. In recognition of this broad approach the Hospital Survey and Construction Act was amended in 1954 to include assistance in the construction of chronic disease facilities, diagnostic and treatment centers, nursing homes, and rehabilitation facilities. The states are currently surveying the need for these facilities and developing plans directed at the construction of such facilities. Need, in general, is a medical concept. Demand is related to ability and willingness to pay for service. The demand today for health services on an ambulatory basis is unprecedented. Our economy and security as a nation place a premium on the worker who can remain on his job because individual production on the farm, in the factory, in our armed forces, in fact, in all phases of our occupational life, aggregates to a national total production that is essential to our preservation as a democracy. Good health is the underpinning of the productive worker. Accurate and effective health education programs underlie the effective use of our health resources.

Facilities for the diagnosis and treatment of ambulatory patients logically may be developed as part of the hospital of the future. Such facilities support the physician in his effort to provide total health care to his patient. Increasingly, such hospitals represent mobilization depots for the instruments of precision which are so important in the diagnostic phase of total health care.

Although they are not properly hospitals, facilities for the care of those who are not acutely ill but who require skilled nursing care and physicians' services are actually a medical care facility and as such will more and more frequently develop intima.e working relationships with hospitals. In some communities these nursing homes will be located on the hospital grounds and operated by the same governing board. Good nursing homes, adequately staffed with competent health personnel, are greatly and urgently needed. As the characteristics of this nation's population become clearer, facilities of the good nursing home type will be in great demand.

Facilities for the care of the chronically ill requiring hospital services represent one of our nation's unmet needs. (Another, of course, is adequate mental health facilities.) In some communities the general hospital serves the acutely ill and the chronically ill requiring hospital services. In other communities, hospitals serving only the chronically ill are developed. The question of which way is best can only be decided at the community level. Each community has its own patterns of medical practice, its own patterns of social service and welfare programs, its own pattern of life and ways of solving problems. This, of course, is as it should be.

Rehabilitation facilities should be

We Must Use Hospitals More Effectively

CECIL D. SHEPS, M.D.

HOSPITALS have been most effective thus far in the care of the acutely sick. What about those who have just been sick and may relapse again soon? What about those who are about to be sick? Should the diagnostic facilities and the teamwork of the hospital be restricted only for use on behalf of the patients admitted to its beds or its indigent outpatient service? Or is it feasible to make it available to the medical profession on behalf of self-supporting patients? Is there something to be learned, not only from the development of group practice units, but also from those units which have developed intimate physical and functional relationships with the diagnostic facilities of hospitals? Realizing that the cost of operating diagnostic services is borne by the community, whether these services are rendered in the hospital or in the "Medical Arts Building," do we have some responsibility to ensure the most effective use of such facilities?

Medical social work has strikingly demonstrated the counseling help it can give in planning to meet the problems of developing a program for patients requiring community resources of various types and also those needing help with family relationships aggravated by chronic or catastrophic illness. Can private patients use such help too? Should this be available to the private physician and his patients?

The hospital as an educational center. It functions as such for physicians, nurses, social workers and many others, not only in preparing them for their profession, but also in extending their education continuously throughout their professional lives. Such education cannot be grafted on to the ongoing patient care activities. The quality of this education is directly dependent upon the framework of patient service. The two are interdependent. They cannot be divorced but, rather, need to be unified. The community hospital will receive the most direct benefits in the improvement of the quality of patient care when all the hospital's activities provide a basis for professional education. What is the lesson in the oft-repeated and often true statement, "The best medical care is to be seen in the public wards of a teaching hospital"?

The hospital as a center for medical research. Medical research which started at the laboratory bench extended, after the turn of the century, to the hospital bedside. Now, as the hospital extends its services into the community, research follows these services. This is essential if we are to evaluate adequately and scientifically the progress of disease and the effectiveness of new diagnostic and therapeutic measures. Clinical research of this type is essential. It complements the basic science research in the laboratory and cannot be done without the personnel and the opportunity for controlled observation and recording of data found in a hospital.

It is generally accepted nowadays that research activity in a hospital raises its standards. This is true only if the researchers and their work permeate the medical care activities of the institution. The best type of research, if it is located "across the street," has

(*Continued on Page* 94)

Dr. Sheps is executive director, Beth Israel Hospital, Boston, and lecturer on preventive medicine, Harvard Medical School.

developed first at medical centers or the university teaching hospitals. The scope of adequate total rehabilitation services requires many skills and competencies in addition to those which are specifically medical in nature. There is a great deficit of trained workers in the rehabilitation field. The training of additional workers then is essential. Medical centers and the university teaching hospitals are the logical places for such training programs. The future hospitals at such centers will be developed to include total rehabilitation services. In time, rehabilitation programs will be a part of the program of every hospital. That time will be shortened by the training of the competent rehabilitation worker whether he is the medical, psychological, social or vocational member of the rehabilitation team.

In the technical design of our future hospitals, in addition to the implied changes inherent in development of the program already mentioned, I wish to pose a few questions. To some the answers seem easy, but let me assure you the road is long and arduous from idea to reality.

What about colors and their effects psychologically and physiologically? What about lighting, natural and artificial?

What about noise, temperature, music and their effects on the patient, the staff, the visitor?

Should all or parts of the hospital be air-cooled or air-conditioned? What parts?

What will be the future of all the by-products of the fusion and fission of the atom in diagnosis and treatment; in furnishing power and light; in sterilization procedures?

What will the field of electronics provide in diagnosis and treatment? Will facsimile transmission of x-rays, of electrocardiographs, of pathological slides, among others, be routine instead of uncommon as it is today?

What about television as a teaching aid both within the hospital and to the large hospital from other smaller hospitals, or to and from the community in health education programs?

What is the rôle of the dentist in hospitals?

A somber note: Should hospitals in certain critical areas include protective features against devastating devices of our current atomic age? Should these hospitals rearrange or plan their design so that they can provide effective daily service and yet be in a state of readiness if catastrophe comes, with its overwhelming demands? What about dispersal and the hospitals?

Here are some broader questions with even broader implications:

What is effective bed utilization?

Do we utilize hospitals properly?

Are patients overhospitalized because of the availability of voluntary prepayment plans?

Can feasible voluntary prepayment plans be developed to pay for diagnostic services for the ambulant patient?

Can the costs of indigent hospital care be covered adequately? How?

Do hospitals need subsidy? If so, how and what?

These are but a few of the questions that face us. I do not know the answers. I do know that research is necessary to arrive at the answers.

This year the 84th Congress made available for the first time federal funds for research demonstrations and experiments in hospital services, facilities and resources through a grant-in-aid program to be administered by the surgeon general of the Public Health Service. To all of us in the health and hospital field this research program is essential and can well help answer the question: "What about future hospital construction?"

There Will Be More Hospital Mergers

JOHN H. HAYES

WE ARE passing out of the age of large wards in general hospitals, and this trend should continue. People do not like to be considered as wards of government or of groups of fellow citizens. I think we will gradually do away with the classification of patients by the areas they occupy and consider them as they are considered in hotels, as occupants of rooms by numbers, charging them according to the accommodations.

Hospitals will find it of financial advantage to set aside sections of their buildings for convalescent patients still needing some hospital care after acute illnesses. The home care programs will take care of many others. There should be sections for the care of long-term cases, chiefly our older people, at lower costs.

There will be more mergers of hospitals, particularly in larger communities.

The training of interns, nurses, dietitians and technicians will become more and more a community undertaking among all the hospitals. Some means will be found to help relieve hospitals with nurse training schools of some of the high cost of nurse training.

The campaigning for new building funds will be a community undertaking for groups of hospitals. This has been done successfully in Detroit, New York and other places. No doubt there will always remain the desire of some people to give funds to individual hospitals, according to their faiths, racial groups, or because of a pleasant experience in a certain hospital. This should not be discouraged.

The collection of blood by hospitals will become a hospital community effort where it is not entirely a Red Cross activity.

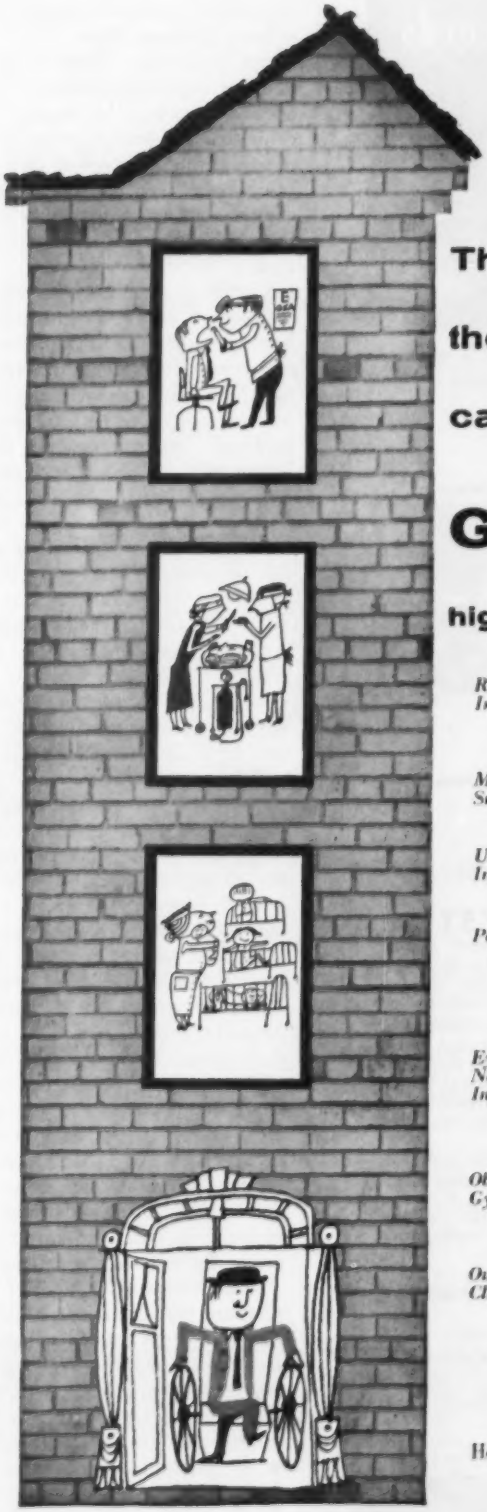
Many doctors may not look upon it with favor, but there will be an ever growing number of doctors working on a full-time basis in hospitals, either as individuals or in groups. More hospitals will build doctors' offices adjoining the hospitals as a convenience to both doctors and patients and in order to promote better use of x-ray, laboratory and other diagnostic equipment which is now too often duplicated and thus expensive because of infrequent use.

Ways will be sought, and I hope found, to promote the sale of full hospitalization insurance coverage. I am afraid that if this is not done there will be a growing dissatisfaction with the insurance available, with resulting pressures for socialized medicine. This would result in less efficient hospital care and even higher costs, despite what the proponents of government insurance contend.

It is not possible to foresee a lessen-

(*Continued on Page 96*)

Condensed from a speech delivered at the annual dinner, Public Health Federation of Cincinnati, December 1955.



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We Must Use Hospitals More Effectively

(*Continued From Page 90*)

little effect upon the hospital except to bring it honor. Here, too, the need is for unification. Direct benefits in terms of improved patient care in the hospital can best be assured if the clinicians involved in research also have patient care responsibilities which bring them into day-to-day intimate contact with physicians whose primary responsibility is the care of patients alone.

The hospital as a center for community health. How can the hospital best meet the over-all health needs of the community? Home care programs have demonstrated their effectiveness in bringing needed hospital services to medically indigent patients in their homes. Can and should such programs be extended to self-supporting patients needing similar services and can the private physician be made a part of this program? What is the potential so far as prevention is concerned? What about the opportunities for health education when one out of eight persons in the population is a hospital patient each year? What about screening this segment of the population for early chronic disease?

What are the potentialities of joint housing and other forms of cooperation between health departments and hospitals? What about the coordination of medical care facilities? Is the general hospital to remain "acute," "chronic," or both? Don't all categories of illness require the very best of medical and hospital care? If so, what is the price we pay for separating patients by the duration or cause of their illness rather than by the type and intensity of care they require? Does our "coordination of agencies" mean that we have an armed truce with each agency having territorial rights outlined which it carefully guards, or do we have a free and ready flow of patients in whatever direction best meets the need of the patient?

These complex functions of the hospital are ever changing. Nowhere are they completely defined and developed. If we wish to face up to our task in the present-day world, if we want to meet the challenge of this century, we can do nothing less than address ourselves as directly as possible to the achievement of our ultimate aim—the development and conservation of human life and personality—difficult and complex though that might be.

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There Will Be More Hospital Mergers

(*Continued From Page 92*)

ing in hospital costs because almost 90 per cent of the costs are in labor and the cost of food. However, the public must learn that good hospital care costs money, and why, and must learn to budget for it.

Although there is a constant interchange of ideas among hospitals they actually compete with one another because each tries to give the patient as much as possible at the lowest possible costs. The product of hospitals is service, which means willing hearts and hands, plus modern equipment. Many hospital workers today do not seem to be imbued with the same spirit of self-sacrifice and desire to help others which I found in hospitals 30 years ago.

I know that there are thousands in hospitals who would heartily disagree with me because there are so many who still have that spirit. However, there are many doctors and others who have noticed this change and have commented on it. And this situation is true in many places other than hospitals.

HOSPITALS PARTLY TO BLAME

Perhaps hospitals are partly to blame for this. In trying to relieve the graduate nurse of nonnursing duties and providing care to the patient by a team rather than by individuals I believe we have lost much of the personal touch. This was done to promote economy and at the same time provide necessary care not otherwise available. I also mentioned that 30 years ago we gave our workers full maintenance, health care and, above all, security. Today we have to recreate in them that feeling of security—the feeling that they are as well off as those in other fields of endeavor. That means they must have the ability to compare their take-home pay favorably with that of industrial workers.

We have done much in this direction; but there is more to do. Where we will get the money with which to do it is another matter; but it seems to me that a desire to be helpful to others usually follows when people themselves feel secure.

The hospitals of this country have much reason to be proud of what they have done and are doing. It is a mark of distinction to be a worker for a hospital, whether as a trustee, a doctor, a volunteer or a paid worker.

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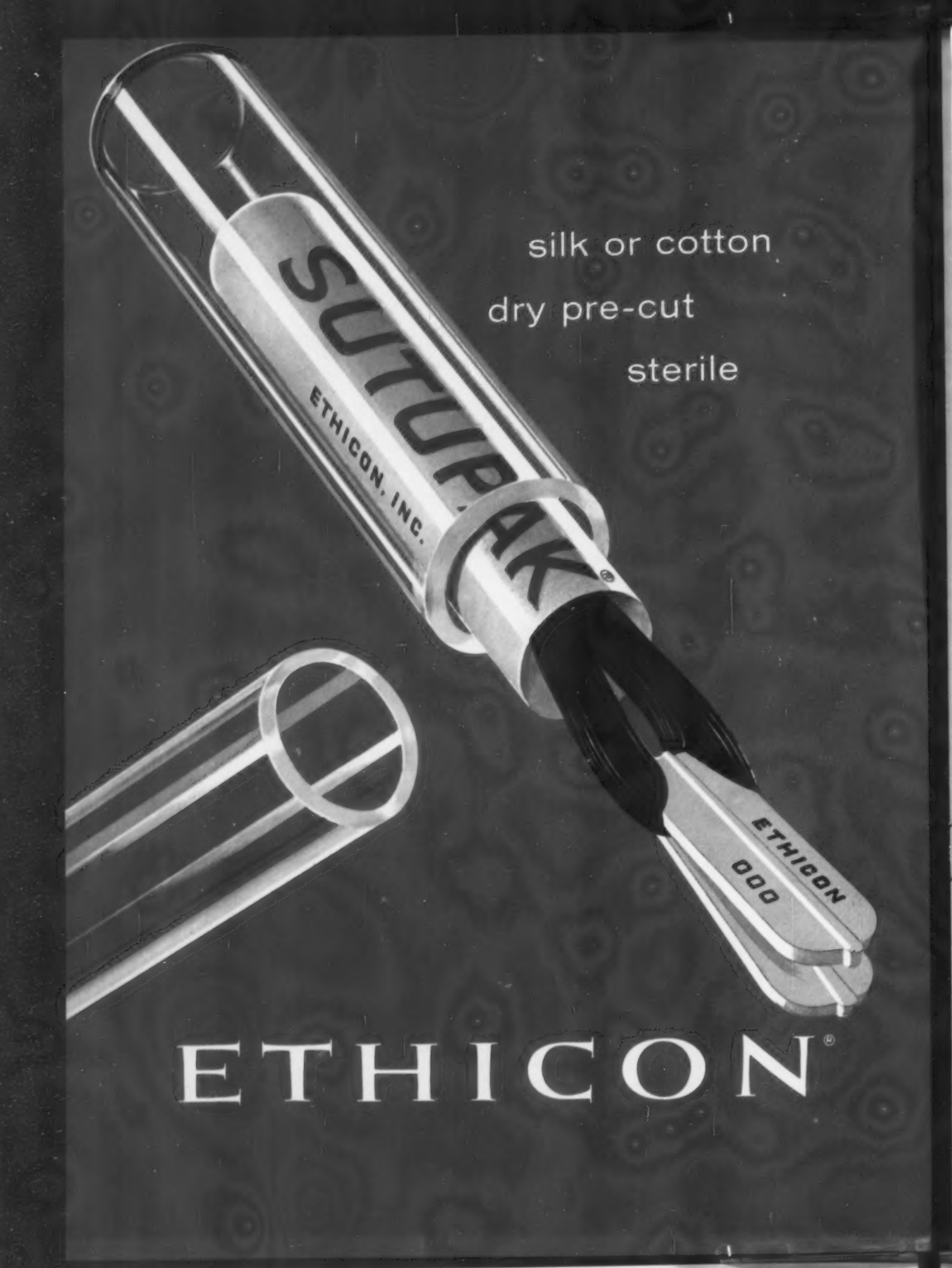
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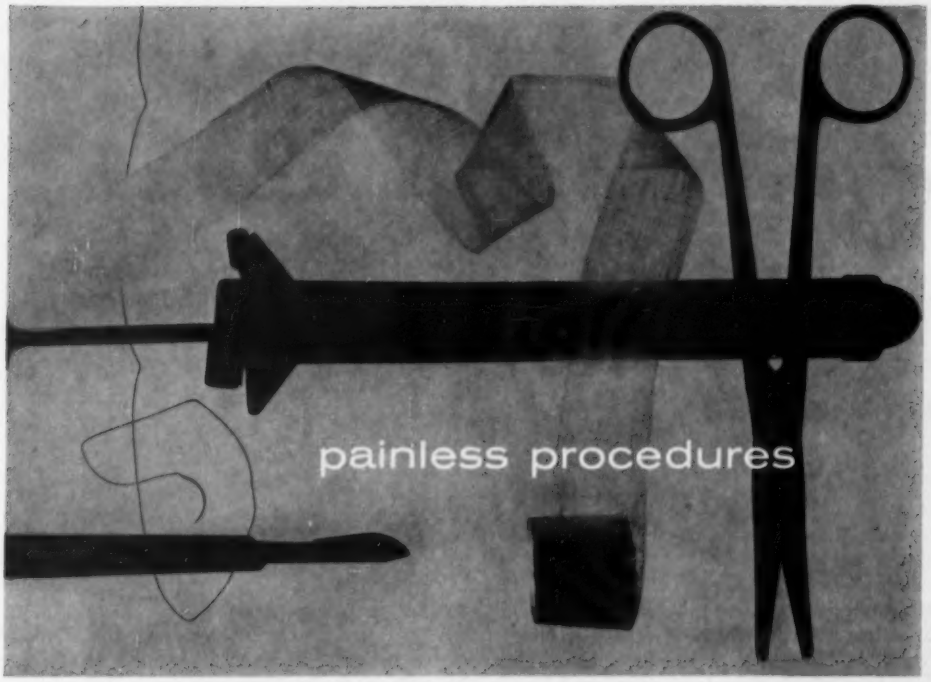

Two Ideas in Search of Acceptance

1. Use Delivery Rooms for Clean Gynecological Surgery?

ROBERT H. LOWE, M.D.

AT AN institute on the dynamics of organization conducted by the American College of Hospital Administrators the hypothesis was advanced that there is a place and need for research (surveys) in business organizations such as hospitals. It was dramatically proved that something can always be observed, discovered, initiated or innovated if one will cease to take things for granted and observe with an interested eye what his fellow workers are doing.

OUTSIDERS NOT NECESSARY

Teams of professional surveyors obtained at considerable cost from outside sources are not necessary to initiate a research program. In fact, such teams would be hard to obtain nor would their solicitation be justified if the administration had not already proved that it knew what research was, how it should be conducted, and what goals were desired. This can only be demonstrated by the administration's doing some research on its own. Every procedure in a hospital, no matter how simple it may seem, can be surveyed with an eye to finding a better way of doing it. Start some little research projects on your own and the big ones, with the necessary help, will follow along.

There are many phases of routine operations that can and should be explored. Some of these are balancing production, unnecessary duplication of equipment and personnel, "string saving" routines, and attempting to streamline procedures. Here is one method by which production can be balanced: Use delivery rooms for clean gynecological surgery, including cesareans, hysterectomies, suspensions, therapeutic abortions and sterilizations, and D&C's plus such others as the chief of service may consider proper.

Larger hospitals with a delivery incidence of 1000 plus per year which also perform a sizable amount of elective surgery are constantly having either a "feast or a famine" in the delivery room while there is always a famine in operating room time. As a result, elective surgical cases, and many of them may be compensation cases, have to be booked from four to eight weeks in advance. This rankles the surgeon and causes the patient a great deal of unhappiness as well as lost income or uncomfortable home life.

Virtually all gynecological procedures, with the exception of the occasional cesarean section, are elective and can be performed at the convenience of the surgeon and the delivery room staff. They are always performed for the convenience of the patient.

DELIVERIES ARE LISTED

All hospitals maintain a list of anticipated deliveries for the delivery room. This, of course, is subject to precipitate change; nevertheless it can be used as a scheduling guide for gynecological surgery bookings. Why not schedule a D&C, a suspension or a hysterectomy in the off times?

An attempt to do this one or two decades ago would have invited immediate rejection. Today, however, thanks to research such as the following, it is not only possible but has been done.

1. *Specialization.* Gynecology is no longer regarded as just another surgical operation designed to remove a vague complaint. It has become a specialty and, increasingly, surgery is performed only when justifiably indicated. Consequently, operative procedures are now accomplished by physicians who have qualified themselves as experts on that portion of the body. Their diagnoses and technics are better, their times are faster, and the patient morbidity is reduced.

PROCEDURES HAVE IMPROVED

2. *Accreditation.* The program instituted by the American College of Surgeons and now being expanded by the Joint Commission on the Accreditation of Hospitals has removed many of the question marks which formerly confronted the chief of service, the surgeon, the operating team, and the administration. Training, since it has become more sharply delineated, has led to more qualified specialists. Procedures have improved because of specialization. Standards, which formerly were hard to measure, have been established. Control of cases admitted is also easier to regulate because of the improved training, technics and standards which may be used as guides by the chief of service.

3. *Antibiotics.* This measure of control is mentioned with reluctance for fear that they may be used routinely rather than only when indicated. It is recognized that they do have

Dr. Lowe is administrator, Indianapolis General Hospital, Indianapolis.

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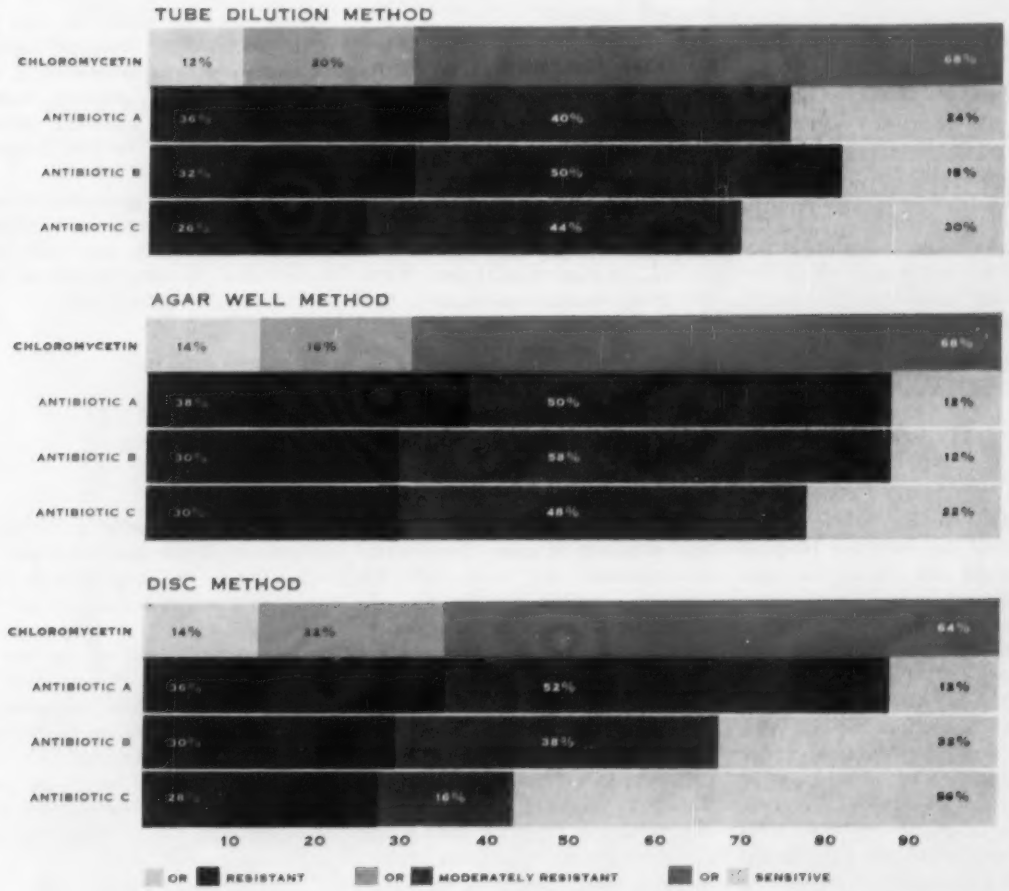

*Breakdown of gram-negative bacilli—Coli: 11; Proteus: 10; *Klebsiella pneumoniae:* 9; Aerobacter: 7; Pseudomonas: 7; Achromobacter: 2; Paracolon: 2; *Salmonella typhosa:* 1; *Bacterium anitratum:* 1. Adapted from Branch, A.; Starkey, D. H.; Rodgers, K. C., & Power, E. E.: Antibiotics Annual, 1954-1955, New York, Medical Encyclopedia, Inc., 1955, p. 1125.

CHLOROMYCETIN *is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.*

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their place and that they have contributed immeasurably in fighting infection but again their use should be dictated by definite indications. They are often used in obstetrical cases. Are gynecological cases any different?

The hazards that may ensue from the changes suggested here are few and can be virtually eliminated if: (1) there is a qualified chief of service adequately supported by the medical staff and the administration, and (2) standards applicable to all concerned have been established and are enforced.

The advantages are many, chief of which are:

1. Adoption of standards leads to competency.
2. Competency brings more certain diagnoses, more definitive treatment, and better patient care.
3. Morbidity is reduced.
4. Waiting time is reduced, the defect is corrected sooner, and a return to a functional way of living is expedited, with resumption of earning power.
5. Idle hands become soft and inept, while busy hands are firm and certain.

To the average assistant the routine delivery followed by a period of idleness may become boring and boredom engenders casualness if not carelessness. The gynecological fill-ins will eliminate the boredom and the attendant demands caused by the diversification of procedures should make what may have been a chore now a stimulating challenge. Service standards will improve.

NO EXTRA EQUIPMENT

6. Equipment. Additional instruments will not be necessary since a transfer from operating room to delivery room cabinet will be all that is necessary. The use of operating tables depends entirely on the whim of the operator. One hospital performed 558 gynecological cases in one year using obstetrical tables only. Formerly, these cases would have been done in the operating rooms on operating room tables. The existing sterilizers should suffice or the necessary procedures can be carried out in the central supply room.

7. Segregation of gynecological surgery will enhance its recognition as a true specialty and not just another surgical procedure. Such specialization will become nationally recognized and impressions that have been offered for public consumption and misinterpretation will be corrected.

8. A measurable amount of increased operating room time will be made available for nongynecological elective surgery, again expediting returns to functional ways of living, return of income, increased patient satisfaction, and a happier surgical staff.

Performing clean gynecological surgery in delivery rooms will balance production which in turn will lead to increased efficiency, production and a decrease in operating costs.

2. Why Not Deliver Babies in the Operating Room?

SEVERAL years ago at the annual meeting of the American Hospital Association the idea of using the operating rooms for deliveries was presented in the discussion following a session on hospital planning. After the tumult and the shouting had subsided, another of the discussants stated: "This idea is not as crazy as it sounds. Several years ago I was engaged as the architect for a new hospital to be built in one of the states below the Mason-Dixon line. The white people in the town were assured that no colored baby would be delivered in the delivery rooms; it was really quite simple—all colored babies were delivered in the operating rooms."

ELIMINATE DELIVERY ROOMS

It is sincerely believed that all hospitals having an annual delivery incidence of less than 1000 should seriously consider eliminating delivery rooms and using the operating rooms for the two or three deliveries they are called upon to perform daily.

At the risk of laboring the point, I would like to point out that all hospitals are faced with a demand to cut costs but at the same time to maintain high standards of care. "Care" items are expensive and when 5,000,000 units of penicillin per day are prescribed for a patient or the operating room requisitions a new, complex and expensive surgical instrument that will probably be used only three or four times a year—the immediate reaction on the part of the administration is to cut down, do without, and thereby save money. By so doing, however, the administration is exposing itself to the charge of practicing medicine because, in effect, it is prescribing for a staff member's patient. No one wants to be found guilty of such a charge.

The administration is charged with providing service for its patients from the community at the lowest cost at which this service can be produced efficiently. It is, therefore, the responsibility of the administration to study methods of plant operation, effect economies and increase efficiency, thereby making it possible to provide the services which the professional staff feels are essential for optimum patient care.

Many of us talk about the tremendous improvements that have been made during the past 10 or 15 years; we remark on the accelerated pace at which we are traveling today as compared with only a decade ago, and we wonder what the next thing is going to be that will speed up our way of living even more. Yet, how many of us sit down and consciously attempt to apply these speeded up mechanisms to our own plant operations? We have been producing good results for years with measures and methods adopted years ago. Are we too satisfied or perhaps even remiss?

DEFEAT RISING COSTS

Hospital administrators must formulate strategems that will defeat that increasingly powerful enemy—public attack on the cost of hospital care.

Such a strategem is hereby presented. Eliminate delivery rooms in small hospitals by using operating rooms. There will be many objections, some real and some fancied. Chief of the real ones will be:

1. Staff opposition. Surgeons will gird against obstetricians and the obstetricians will joust back. It is, therefore, essential that exploratory meetings

be held with representatives of all services affected. It is also essential that the board of directors be represented, for the board is responsible to the community and should authorize and be prepared to explain what may well be considered a poorly advised revolutionary step. It might well be advisable to include representation from the local health authorities in such meetings.

2. Deliveries can't wait. Neither will the surgeons allow the ruptured peptic ulcer, the red hot appendix, or internal hemorrhaging to wait. Also, what do you do now when your delivery rooms are full and a precipitate mother arrives?

3. Infections. Operating and delivery rooms are both cleaned so that a "clean" case may follow a "dirty" case. In fact I'll wager that today some known "dirty" obstetrical cases are shipped to the operating rooms for delivery. If standards are maintained there is no danger in a "clean" case following a "dirty" case.

4. Nursing. A delivery is a surgical procedure and, therefore, it is entitled to the best supervision available. In general, operating room supervisors have better all-round training. Why not assign the delivery room supervisor as an assistant to the operating room supervisor for broadened training and experience? This would bolster the operating room staff, too.

WHY IT SHOULD BE CONSIDERED

The following reasons are presented to substantiate the claim that combining delivery rooms with operating rooms should be seriously considered not only in new construction but in already existing facilities.

1. Patient care. There is little to fear on this score. Improved standards and procedures for both facilities and care have infinitely reduced the risk to the patient.

2. Consultations. Surgical consultations and assistance, especially in the smaller hospitals which would be affected by this combination, are occasionally desired. The operating room is the surgeon's habitat and he will be only too ready and willing to help.

3. Personnel. As has been pointed out, making a team of the operating and delivery room supervisors will strengthen the patient care program. In those hospitals where the delivery room supervisor position is vacant, and has been for some time, it is an immeasurable relief to be able to rely on

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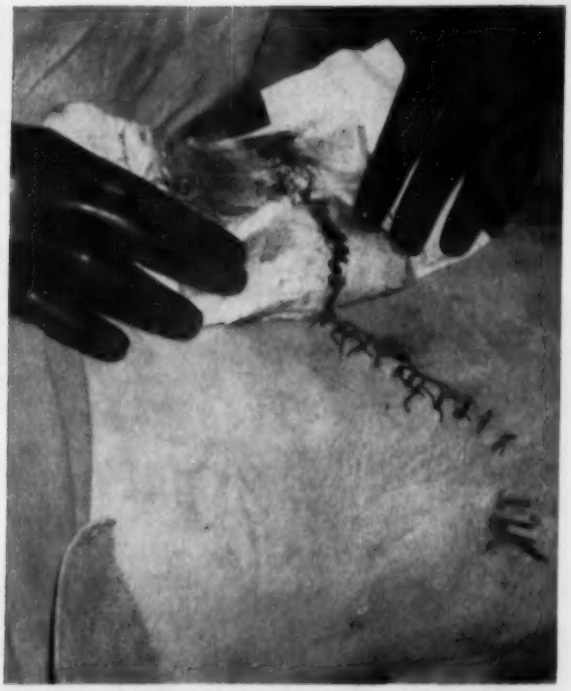

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You can use TELFA Non-Adherent Dressings on *all wounds* because they are supplied in both TELFA Strips and TELFA Sponge-Pads, to meet every wound need.

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the operating room supervisor. The day may come when postgraduate courses for training operating room or delivery room supervisors may easily become *one* for operating *and* delivery rooms. Such a combined training course could do a great deal to fill the demand for especially trained qualified personnel.

Oftentimes, now, floor nurses are pulled off obstetrical units and sent to the delivery room because that unit is shorthanded. This reduces what may be an already thin postpartum patient care staff. Operating room nurses, however, are sent out to floors if the operating schedule is light and they are, therefore, readily available for recall. The point is that specialized personnel is already available in the operating rooms and desired personnel for delivery room staffing does not have to be added even if it can be found.

4. Labor rooms. Labor rooms should be close to the delivery rooms. How many now are? In new construction this conjunction can be easily achieved. In already existing facilities some innovations may have to be made.

5. Recovery rooms. More and more hospitals are recognizing the need for surgical recovery or postoperative rooms and are creating such facilities. Post-delivery recovery rooms are occasionally urgently desired but the demand does not justify their establishment. If, however, deliveries were to be performed in the operating rooms the surgical recovery rooms can and should be made available.

6. Anesthesia. Seldom is an anesthetist assigned full time to the delivery room in a small hospital. He is called from the operating room when needed and is sometimes hesitant about leaving his domain. If he is busy an intern or a nurse is drafted and the crisis is waded through. If deliveries were done in the operating rooms and the anesthestist was busy he still would be available for consultation or even part-time assistance.

7. Patient care. Patient care cannot help but be enhanced and morbidity reduced when patients are delivered in the operating room.

8. Duplication of equipment. Many existing duplications can be eliminated. Among these are surgical instruments, lights, stools, basins, stands, towels and drapes. The delivery suite sterilizing unit will no longer be necessary since already existing operating or central supply room facilities are sufficient and capable. Delivery tables will simply be moved to the O.R. suite and used as alternates as operating tables are alternated. Equipping a delivery room may cost anywhere from $10,000 to $25,000. Why spend it?

9. Duplication of construction. Delivery rooms are virtually identical with operating rooms. At the low price of $2 per cubic foot one can cost $8000 to build. In addition to the initial construction must be added maintenance and operating costs such as light, heat, power, steam and depreciation. Why build duplicate operating rooms?

10. Centralization of personnel and equipment. This result cannot help but increase efficiency and reduce expense.

11. What to do with it? In hospitals which now have delivery room suites but can see their way clear to combining them with operating rooms, this question may come up. The hospital has yet to be seen that is not looking for more room. Some possible uses for the extra space are: (1) physical therapy department; (2) laboratories, pathology, medical photography; (3) obstetrician's office, examining room, laboratory, clinic; (4) anything you are now being hounded for.

Common Causes of Household Poisoning

A report on the common toxic substances found in every home and recommendations for overcoming the hazards

"THERE is no place like home" is an old adage that suggests a haven of security, peace and protection. Oddly enough, it is really a paradox: The home is, in fact, the most dangerous area for living since more accidents and poisonings occur here than anywhere else. While it is true that many of these mishaps are not fatal, too many are either fatal or leave the victim crippled.

It is not possible to give a specific figure for the number of poisonings because a reporting of such cases is not mandatory. One can reasonably estimate that several thousand accidental deaths due to poisons occur yearly, and that many times that number actually happen but are not reported or recorded.

POISON CENTERS ESTABLISHED

The problem is of such proportions that the American Academy of Pediatrics has sponsored the establishment of poisoning centers in many areas. The first of these was developed in Chicago by Dr. Edward Press,* who effected an organization which has been copied in many areas. Recently, the American Medical Association has established a committee on toxicology, with Dr. Torald Sollman as chairman. A great deal can be expected from these two organizations to help correct the rapidly growing number of poisonings.

One might ask: "How many toxic substances can be found in a home?" It is estimated that a quarter of a million products usable in the home are now on the market, and more are being added daily. This doesn't mean that there are 250,000 different toxic substances, since many manufacturers produce comparable products. For example, there are about 7000 pesticides available, but probably not more than 50 toxic substances classified as pesticides. It should be appreciated that manufacturers place their products on the market for a definite purpose, to be used in a definite manner, and usually with very specific directions. Unfortunately, labels do not always indicate the presence of a poisonous substance. Too, it is evident that the average person does not read labels, and certainly cannot be expected to be acquainted with the poisonous properties of a rather large number of substances even when these are listed on the label. Furthermore, familiarity arising from repeated use of a product without any deleterious effect leads to carelessness, indifference and misuse of it, oftentimes with disastrous results.

Since children are most frequently involved in these misadventures, parents must be informed of the possibilities existing in the home which may lead to poisoning. It is quite impossible to list all the poisonous substances in daily use because of the large number, but groups of substances and areas of danger can be considered.

The Medicine Cabinet: Most medicine cabinets are catch-alls and depositories for unused portions of prescriptions and innumerable items, many of them highly poisonous, often in unlabeled containers. Of course, the cabinet is never locked and entry is always available to the inquisitive child who, having seen the parents take a pill, imitates, and often empties the container, especially if the taste of the contents suggests candy. Aspirin poisoning is a common consequence of such imitation, much commoner now since flavored aspirin tablets have been introduced.

CAN NEUTRALIZE DANGER

The danger of the medicine cabinet can be neutralized by following some simple procedures. All unused prescriptions should be discarded. The drugs were prescribed by a physician for a definite condition at a definite time, and were never meant to be kept and used again for any condition which may be fancied to be similar. Self-medication is always fraught with danger. The medicine cabinet should not become a storage place for such items. A prescription being used should not be put in the cabinet, no matter how handy it may seem, but should be kept in a place where it is impossible for a child to reach it.

No unlabeled containers should be kept. Memory is short and one of the commonest mistakes people make is to assume that the contents of a container is some particular substance. Transference of one product to another container without the label's being changed, such as placing bichloride of mercury tablets in an aspirin bottle, is another source of trouble. Such items as bichloride of mercury, potassium permanganate, and compound solution of cresol (to mention a few) should never be placed

*Dr. Press is now in New York City.

in the medicine cabinet. Home permanent wave preparations containing the highly toxic (when swallowed) ammonium thioglycolate and potassium bromate have no place in the cabinet.

It is trite to say that if the cabinet contained no toxic substance poisoning could not occur. And if the cabinet were securely locked, although it might be inconvenient, children could not get into mischief.

Another area of disturbance is the laundry, with bleach, washing soda, bluing and borax standing in the open. Most of the soaps and synthetic soap substitutes are not too toxic. When children are about, the person doing the wash should not measure out, in a glass or cup, bleach or any ingredient to be used, and set it on a table. It is natural for a child, upon seeing liquid in a cup, to be thirsty. Drinking of bleach is a common occurrence under such conditions. Some detergents are highly alkaline, containing borax, polyphosphates and other phosphates of sodium, and should be kept in a locked cupboard. Washing soda is strongly alkaline, being comparable to lye in its effects. Just a minimum of care and thought will decrease the actual and potential dangers of the laundry area.

In this "do-it-yourself" era many noxious substances are left in the open. Turpentine, lead-containing paints, benzene, carbon tetrachloride, kerosene, naphtha and paint remover are a few of these. And usually stored with these is a host of pesticides, some highly poisonous even when spilled on the skin. Extreme care must be used in handling such items, and caution dictates that they should be kept in a securely locked cabinet. Old toys or new productions should never be finished with lead-containing paints, particularly if young children are going to use them, since the habit of putting things in the mouth is almost universal among them, and lead intoxication may occur. Most toy manufacturers do not use lead paints on their products.

While the kitchen is primarily a food area, it is amazing to find a host of poisonous substances stored there. Insecticides, roach powder, phosphorus paste for rats, furniture polish, washing soda (too commonly confused with baking soda), disinfectants, lighter fluid, ammonia, drain and bowl cleaners, and many more items seem to gravitate to the kitchen and astonishingly often are stored indiscriminately with food products. All products of this type should be stored in locked cabinets located some place other than the kitchen. When any of these products is used, extreme care must be taken to make sure children cannot get to them.

Around the house various items are often left without concern—cigaret butts, partially consumed cocktails, sleeping medicines, colognes and perfumes, mascara, hair dye, anti-perspirants, fingernail polish and remover—all of which children have been known to eat or drink. Oil from a leak in a heater pipe line caught in a can seems to be a choice beverage for some children. Moth balls (naphthalene) are also considered a tidbit.

The garden is another area for consideration. Castor beans are highly toxic, as are the bulbs of meadow-saffron. Indian-berry, lily of the valley, and bittersweet berries should also be kept in mind.

While it does not appear practical to reduce the number of toxic substances about the house, a few simple rules followed conscientiously will do much to reduce, to a great degree, the

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number of unnecessary poisonings:

1. Discard all partially used prescriptions.

2. Never store any unlabeled containers.

3. Never put toxic substances in familiar containers (such as milk bottles, soft-drink bottles, cups, glasses).

4. Follow directions given on labels for any particular product, and do not use the product for other purposes. Become thoroughly acquainted with the directions before using any product, and don't let familiarity with a product lead to carelessness.

5. Never transfer one substance to a differently labeled bottle, particularly if the label indicates a common substance.

6. Be sure that substances or products which are toxic are stored in securely locked cabinets.

7. Empty containers should be destroyed. Children playing with apparently empty containers of pesticide account for a major number of deaths attributed to pesticides each year.

8. When painting, removing spots from clothes, or using paint removers, be sure there is adequate ventilation and that drafts do not carry the toxic volatile substances to some other room of the house where it may become pocketed and build up into a dangerous concentration.

9. Be sure that furnaces, gas radiators, stoves or heaters are properly sealed and ventilated, that carbon monoxide is not permitted to collect in a home. Never warm up a car in a closed garage; a lethal concentration of carbon monoxide is reached in a single car garage in about five minutes.

10. In the event an accident occurs, call your physician immediately! Don't wait because the victim appears to be all right. A life may be endangered if the delay is too long.—W. J. R. CAMP, M.D., PH.D.

The Poison Buggy Has the Antidote

THE "poison buggy" is Madison General Hospital's answer to the problem of how to get certain drugs where they are needed in a minimum of time. Originating in the pharmaceutical department as the project of Mrs. Karna Webster, the pharmacist, the buggy consists of a medical supply distribution cart 41 inches high and 20 inches wide. It is made of stainless steel and contains some sixty-six drugs and types of apparatus.

When an emergency poison case comes into the hospital, the first step is to use whatever antidote is nearest at hand. Most technical staff members have some knowledge of poisoning and its immediate treatment but possibly there is no suitable drug on hand. If all the antidotes are assembled at one place, they know without delay whether the required drug is present or whether they must go outside of the hospital for it. Incoming cases of poisoning may be dangerously advanced before attention can be given to them unless the correct medication is there. Once a poison has been absorbed into the body, therapy is considerably less effective.

The idea of the poison buggy in itself is not new, but the convenience it affords can readily be utilized in any hospital. Even the local druggist can set aside a special section in his store for poison antidotes—JACK A. JILLSON, *Madison, Wis.*

Poison buggy set up and ready to go.

Good Food Starts With Good Management

Faced with the need to raise standards and reduce costs, many hospitals are employing food service managers to handle the commercial side of dietary service while the dietitian devotes her energies to nutrition and therapy

JOHN W. STOKES

A BUSINESSMAN who had recently spent several weeks in a modern community hospital reported that the scrambled eggs were tough, rubbery and green. Another former patient complained that although the food was plentiful and apparently of good quality, meals were invariably served cold.

Why are hospital meals so often unappetizing? In view of the per diem rates charged, why cannot patients' meals be on a par with those served in a good restaurant? Are hospital dietary costs generally excessive?

HIGH STANDARDS DO NOT PREVAIL

There is no single answer to these questions. In many hospitals the food served to patients and employes is excellent. On the other hand, unfortunately, high standards of food service do not prevail in hospitals generally. From a cost standpoint it can be stated that few hospitals get as much for their food dollar as does the average well run restaurant.

In extenuation it is only fair to point out that the physical and psychological condition of the hospital patient tends to make him hypercritical. Food does not taste the same to a person who is not well.

Great strides have been made in hospital service in recent years owing, among other things, to advances in medicine and surgery, the new antibiotic drugs, and better trained administrators. The 20,000,000 patients in American hospitals in 1955 got better treatment and stayed about 50 per cent fewer days, on the average, than they would have had they been hospitalized two decades earlier.

It cannot truthfully be said, however, that all of these patients received better food and service than they would have 20 years ago. With some notable exceptions, hospital food service has tended to lag behind in the march of progress. One reason for this, perhaps, is the emphasis that has been placed in hospitals upon the *therapeutic* rather than the *nutritional* function of food. This is indicated by the traditional name used in most hospitals to denote food service, "the dietary department."

Normally, only from 15 per cent to 20 per cent of the patients in the average general hospital require special diets. Thus in a 250 bed institution only from 35 to 50 patients might require therapeutic diets. This means that the problem of feeding the other 200 patients and the 400 or so employes who eat regular meals is essentially that of conducting a mass-feeding operation. Yet the food service in the majority of the nation's hospitals is in the hands of dietitians who have majored in dietetics and nutrition rather than in food service management. This is no indictment of the dietitian, for her true function is food therapy. Indeed it is to the great credit of so many of the experienced executive dietitians in larger hospitals everywhere that by dint of their own abilities and efforts they have become administrators as well as therapists.

Hospital dietary costs have been high in the past because there usually is no effective system of cost control such as would exist in a well run commercial feeding establishment. In the case of a restaurant, the lack of such controls would undoubtedly result in bankruptcy. However, in the hospital, deficits have always been made up either through the contributions of interested individuals, grants from community funds, or by increases in the rates charged to patients.

NOW THEY MUST ECONOMIZE

In recent years sources of large contributions have tended to dry up and in some cases the point of diminishing returns has been reached. At the same time, operating expenses have sharply increased, largely in the area of salaries and wages. Faced with this dilemma, trustees and administrators have been forced to seek operating economies.

As a substantial portion of total hospital cost (from 15 to 20 per cent) is involved in providing food for patients and employes, it is only natural that the dietary department should be a fertile field of exploration for savings and also for improvements.

Out of our experience with many hospitals in the United States and other countries we have yet to find one where savings of 10 per cent *or more* could not be effected in dietary

The author is a management consultant, Boston.

Sexton Menu marvels

...how much PROTEIN?

CHICKEN FRICASSEE	13.9%
CHILI WITH BEANS	9.4%
CHILI WITHOUT BEANS	10.5%
BEEF STEW	7.3%
BEEF IN GRAVY	20.1%
BEEF HASH	9.9%
CHICKEN A LA KING	10.5%
CORNED BEEF HASH	9.4%
BEEF IN BARBEQUE SAUCE	19.4%

CALORIES NEEDED EVERY DAY

60% from starch and sugar
25% to 30% from fat
10% to 12% from protein

costs and at the same time the food service to patients and employes substantially improved.

Most dietaries have so-called "cost-control" systems but too often these systems have little relation to actual costs or to means of control. Frequently the chief function of such devices is to provide statistics for monthly reports—so many "meals" served, such and such a "raw-food cost."

To illustrate: In a New York hospital we found recently that the daily count of "meals served" to patients was computed by multiplying the daily census by three. No allowance was made for operative or other patients who were unable to eat. Also included in the count were the newborn infants. In the employes' cafeteria no differentiation was made between "snacks" and real meals. Obviously, it would be impossible to build a true cost system upon such loose bases.

As to control of food costs, many weaknesses are found. To illustrate: In a Pennsylvania hospital nearly 2000 one-pound cases of coffee were found hidden in an obscure section of the basement. Fresh coffee of the same quality could have been delivered weekly in bags at a cost of five or six cents per pound less (the cost of the cans).

In a Florida institution bags of chopped ice were left melting on the receiving platform for considerable periods of time. Many other examples of lack of control of food and supplies could be cited.

COST CONTROL IS EFFECTIVE

The modern trend is toward effective cost control systems such as we saw recently in Mount Sinai Hospital in New York. Here the food service manager knows what happens to every ounce, for example, of a batch of ground meat going out of the kitchen. This is effective cost control.

In Malden Hospital, Malden, Mass., we noted that each transaction in the employes' cafeteria of 10 cents or less is regarded as a "snack." "Snacks" are recorded separately from "meals" in the cafeteria accounting.

To cite another illustration, Massachusetts General Hospital in Boston recently effected substantial savings in food costs through careful analysis of purchases. Quincy City Hospital has saved from $25,000 to $40,000 annually on dietary costs through adequate cost control following a survey some years ago. Many other examples could be given of the trend toward improved cost control noted in hospital dietaries.

The basic problem, however, continues to be that of management. As hospitals increase in size and as larger numbers of employes must be fed, the management of a hospital food service takes on many of the aspects of a commercial food service operation. The trend, especially in the larger institutions, seems to be toward the appointment of a food service manager, usually a man who has had food experience in hotels or restaurants.

TREND IS NOT NEW

This trend is not altogether new, for as early as April 1938 Columbia-Presbyterian Medical Center in New York engaged an experienced European-trained chef to act as kitchen-manager-steward. Years ago the food purchasing function was often in the hands of a steward. Today the food services in many hospitals in various parts of the nation are headed by experienced food men, ranging from stewards in small hospitals to assistant administrators in charge of food service in some of the larger institutions.

This brings into sharp focus the relationship between the dietitian and the food service manager. For years the dietitian has held undisputed sway over the dietary department. Rules of accreditation require that the hospital to be accredited must have a dietitian who is a member of the American Dietetic Association in charge of teaching dietetics in the school of nursing. There is no doubt that some dietitians view with alarm the placing of the food service under an individual who is not a dietitian. On the other hand, we have talked with dietitians who because of their interest in dietetics as a profession are glad to be freed from the chores and responsibilities, distasteful to them, of the food service management. They welcome the opportunity for greater contacts with the patients and staff in advancing the more widespread use of food as a therapeutic agent in the hospital.

Practice varies as to the division of authority and responsibility between the food service manager (whatever his precise title may be) and the executive dietitian. In some of the larger hospitals the dietitian reports to the food service manager, although in some cases she may also report directly to the administrator with respect to therapeutic diets and teaching duties. In other institutions the two occupy equal positions, both reporting to the administrator. Often where this is the case, the food service manager is responsible for the kitchen and cafeteria and distribution of food to patients. The dietitian is in charge of teaching dietetics in the school of nursing and for therapeutic diets and may be given such a title as "director of food therapy."

Food in the hospital serves the dual function of: (a) nutrition and (b) therapy. With the advent of psychosomatic medicine the interrelation of these two aspects of hospital food will be increasingly recognized. Furthermore, with augmented specialization in the medical field, new types of special diets are being prescribed more and more. This is particularly noticeable in hospitals affiliated with medical schools where the teaching function is emphasized. This leads to the conclusion that the therapeutic dietitian will play an increasingly important rôle in the hospital in the years just ahead.

ONE HOSPITAL CHANGED BACK

There is no doubt that there is a definite trend toward placing hospital food service under an experienced manager. Many of the large hospitals in cities like New York and Chicago now have food service managers. On the other hand, an occasional reversal of this trend is noted. Recently a 700 bed Eastern hospital placed responsibility for the food service, which had formerly been in the hands of the chef, again in charge of the head dietitian with reportedly excellent results.

Whether or not a food service manager can do a better over-all job for the hospital than the dietitian is a question that cannot be given a simple answer. Everything depends upon the individual concerned, his or her personality and background. Most important is the ability to work with people: to lead workers to want to do the kind of jobs they should do. I am acquainted with many women dietitians in hospitals in this country and other parts of the world, who, in addition to their technical training in dietetics, are doing outstanding jobs as managers of their departments.

On the other hand, this ability to manage others is something that requires experience. One must first

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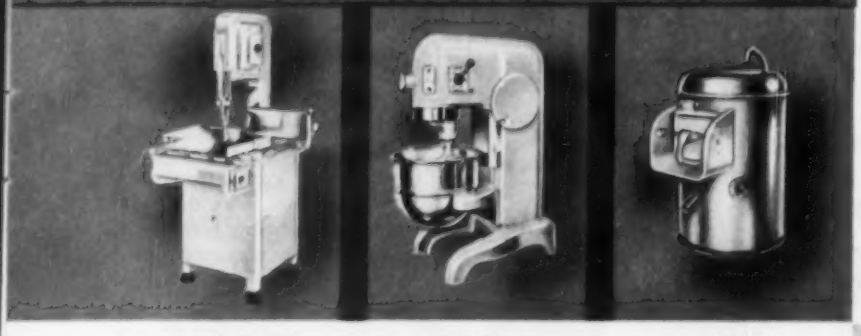

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learn to obey before one can command. Unfortunately, the young dietitian with little or no managerial experience is sometimes placed in the situation of managing cooks, kitchen and cafeteria workers, male and female, all many years older than she. At the same time she must handle therapeutic diets, teach the student nurses, and do the food purchasing—to mention only the major chores expected of her. It is no wonder that she finds the going difficult indeed.

When the administrator decides to engage a food service manager he should know the kind of person he wants. Too often an individual is selected merely because of his knowledge of food. It is as if a symphony orchestra seeking a conductor should offer the post to an outstanding concert artist merely because of his skill with a given instrument. The qualities that make Heifetz a great violinist are quite different from those required by a Toscannini. Many a chef is a great artist in his own field yet may not possess executive ability. It is this ability to delegate responsibility and authority, to hold subordinates accountable, to inspire and lead a staff that is needed in the food service manager. If these qualities are available in the individual, in addition to a sound knowledge of food, one has an ideal person for the job.

In industry, when an important executive post is to be filled, it has been found profitable to have a careful study made of the job, its requirements, and the personalities involved so that the individual selected will be qualified to perform effectively without upsetting the organization.

While there are undoubtedly "born leaders" — individuals who seem to possess daring, initiative and other attractive personal characteristics that cause others to follow their lead— executive ability seems to be acquired through training and experience. I have seen numerous instances of mature individuals who have been trained to become executives, and successful ones, too.

Some years ago, as part of a food service survey, we were asked to determine whether or not the chef, then temporarily in charge, was competent to assume the full responsibility of the operation, comprising approximately 1000 meals daily. The man was of foreign birth and in his late forties. His formal education had not gone beyond the grade school level. Yet he was intelligent, possessed an engaging personality, was an excellent cook, and was ambitious to improve his station in life. In a short time it became clear that the man was of managerial timber and we so recommended. Members of our staff gave him a six months on-the-job training program with subsequent checkups at increasingly wider intervals. By the end of the first year he had made considerable progress. Food quality and service were greatly improved.

That was in 1946. Since that time the man has shown many betterments and savings in the operation under his charge. He has been rewarded with generous salary increases and is happy in his work and alert to new developments in the food service field.

Not only is executive ability required in successful food service management; it is also important that lines of responsibility and authority should be sharply defined. This is particularly true with respect to relationships between the food service manager and the executive dietitian. Who is accountable to whom? What are the responsibilities of each with respect

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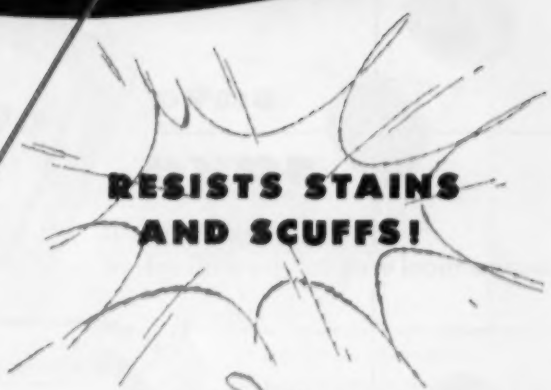

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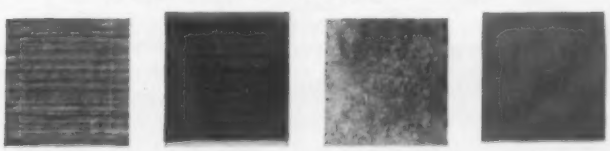

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to purchasing? Quality-control? Food preparation and cooking? Distribution of food to patients? The employes' cafeteria? All of these and a host of other areas need to be clearly marked out and set down in black and white so that there may be no misunderstandings.

"I wish I had the food knowledge of Mr. X," said a dietitian last spring, speaking of the hospital's food service manager. "He is a whiz at that, but he never tells me just what he expects me to do, and seems to resent it when I do what I feel needs to be done."

Such conflicts would be resolved if lines of authority and responsibility were properly defined and outlined.

A food service consultant is constantly impressed with the recurring need for supervision and training in the hospital.

Visiting a large metropolitan hospital recently during the evening hours we watched a young man operate a dishwasher. It was noticeable that bowls and soup plates, instead of being placed in the dish racks in an inverted position, came out *right side up* and full of water. Upon inquiry we found that the machine operator was new to the hospital and no one had ever explained to him how dishes should be racked.

Some years ago in making a survey in a suburban hospital, noted for its management and service, excessive bacteria counts and evidences of pathogenic organisms were revealed by a smear-test of a meat slicing machine. Upon investigation it was found that the operator of the machine had disregarded instructions relating to the daily cleaning of the machine in question. Yet no one of his supervisors had checked to see whether or not these instructions were being followed out.

In another suburban hospital, only a few months ago we found that milk was delivered very early each morning and that the driver was in the habit of carrying the milk into the walk-in refrigerator without any count being made by a dietary employe. While there was no evidence of shortages, the dietary department might well be censured for neglecting to check this delivery.

Countless other incidents might be enumerated which we as consultants see in hospitals—large and small—day after day. Most of these lapses are the result of lack of proper training and adequate supervision.

The food service manager has not done his job unless he sees to it that all dietary employes are adequately trained for their jobs and given constant supervision. Supervision cannot be effective on a "touch and go" basis. It must be given day in and day out. The food service manager and his subordinates must keep everlastingly at it if he would achieve success in supervising employes.

Another new trend in hospital food service is the employment of outside caterers to handle food service to patients and employes. A number of the industrial catering firms which have been successful in operating employes' cafeterias in industry are today offering their services to hospitals.

As yet it is too early to evaluate this latest dietary trend. Some hospital administrators who have engaged such outside catering services are enthusiastic over the results obtained. One of the advantages reported is the savings effected through the ability of these large national catering services to purchase more advantageously than the local hospital.

On the other hand, the administra-

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tor of a large city hospital with whom we discussed this problem recently felt that his institution was large enough so that he could purchase just as advantageously as could an outside organization.

Administrators using outside caterers feel that they have been relieved of the "headaches" associated with dietary service. Others cite the objection that patients and employes may resent an outside agency making a profit on the hospital's food services.

It should be pointed out that in several institutions where outside caterers are responsible for the operation the quality of food and service seems to be highly satisfactory.

Another interesting recent trend in hospital food service is the effort to develop new and better means of getting the food from the kitchen to the patients. The decentralized method is the one whereby the conventional electrically heated truck transports food in bulk to the floor pantry. Here it is dished out and carried in to the patient who, may it be said parenthetically, accepts it for better or for worse.

As against this more or less traditional method many hospitals in recent years have installed various types of centralized food service. Under this plan the food is served in the kitchen, placed in trays, and conveyed in insulated trucks or containers directly to the patients.

In the centralized plan the food is served under the watchful eye of the dietitian or food supervisor in the kitchen, thus ensuring uniform portions. Also it is not subjected to the deleterious effects of excessive heating in the truck which tends to dry out the food and make it unpalatable.

A by-product of importance under this latter system is the freeing of space now devoted to floor pantries for more profitable use. For example, in a Connecticut hospital where additional beds were greatly needed it was estimated that the conversion to bedrooms of five former floor pantries is now producing an estimated additional $60,000 of income annually.

The "mobile cafeteria" type of service is one of the latest "wrinkles" in assuring that patients get hot food hot and cold food cold. Under this plan the truck is equipped with heated and refrigerated food compartments and all of the dishes, utensils and trays required for as many as 100 patients. It is loaded in the kitchen and conveyed to the corridor outside the patient's room where the food is served.

FOUR OBJECTIVES TO ACHIEVE

Assuming that food of good quality is purchased to begin with and that it is properly prepared and cooked, there are at least four objectives which an adequate system of food distribution should achieve. These are:

1. To provide patients with hot food that is *hot* and cold food that is *cold*.

2. To reduce to a minimum the interval between the time the food has been cooked and the time it reaches the patient.

3. To minimize the handling and motions required in getting the food from the kitchen to the patient.

4. To maintain the highest possible standards of sanitation throughout the entire distribution process.

There is no single method of food distribution under which these four objectives can be attained. The best method for any hospital is that method best suited to the peculiar conditions existing at that institution and its own operating policies.

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Menus for March 1956

1 Tomato Juice Bacon, Hot Biscuits • Boiled Corned Beef Brisket Boiled Potatoes Boiled Cabbage Pickled Beet Salad Rhubarb Pie • Chicken Noodle Soup Beef Steak Pie With Fresh Vegetables Tossed Green Salad With French Dressing Peaches Chocolate Mint Cookies	**2** Apricot Nectar Scrambled Eggs, Toast • Oven Fried Sole With Tartare Sauce Parslied New Potatoes Fresh Spinach Fresh Pineapple and Banana Salad Orange Alaska Chiffon Cake • Tomato Soup Creamed Mushroom, Tuna and Noodle Casserole Frozen Peas Cabbage Slaw Upside-Down Cake	**3** Stewed Prunes Poached Eggs, Toast • Yankee Pot Roast With Horseradish Sauce Browned Rice Buttered Small Onions Tomato Salad With 1000 Island Dressing Ginger Whip With Whipped Cream • Fresh Vegetable Soup Cold Corned Beef With Mustard Sauce Parslied New Potatoes Frozen Fruit Salad Chocolate Cupcake	**4** Orange Juice Broiled Canadian Bacon • Fried Chicken Mashed Potatoes Buttered Asparagus Head Lettuce Salad Chocolate Sundae • Split Pea Soup Cheese, Crackers Fruit Plate: Orange Sections, Fresh Pineapple and Elberta Peach Half, Garnished With Marachino Cherries Filled Cookies	**5** Half Grapefruit Shirred Eggs, Muffins • Breaded Pork Chops Escalloped Potatoes Broccoli With Hollandaise Sauce Fruit Gelatin Salad Orange Soufflé With Orange Sauce • Corn Chowder Beef Steak, Kidney Stew Wilted Vegetable Salad Fresh Rhubarb	**6** Grape Juice Broiled Canadian Bacon • Beef Rib Roast Mashed Potatoes Buttered Whole Carrots Tossed Vegetable Salad With Roquefort Dressing Tapioca Cream Pudding • Chicken Giblet Soup Deviled Eggs Vegetable Plate: Whole Kernel Corn, Frozen Peas, Carrots and Beets Pears
7 Sliced Oranges Soft Cooked Eggs, Toast • Veal Birds Parslied New Potatoes Asparagus With Cheese Sauce Vegetable Relish Plate Butterscotch Ice Cream • Scotch Broth Chicken Timbales With Bechamel Sauce Creamed Rice Sliced Tomato Salad Apricots	**8** Apricot Nectar French Toast, Sirup • Braised Short Ribs Franconia Potatoes Mashed Turnips Cardinal Vegetable Salad With French Dressing Strawberry Shortcake • Fresh Vegetable Soup Cold Glazed Ham Loaf Baked Sweet Potatoes Fresh Fruit Salad Pecan Rolls	**9** Half Grapefruit Poached Eggs, Toast • Baked Halibut With Tartare Sauce Baked Potatoes Harvard Beets Cabbage Slaw Apple Cobbler • Cream of Mushroom Soup Cheese Soufflé With Spanish Sauce Buttered Peas French Salad Bowl With French Dressing Pears	**10** Tomato Juice Scrambled Eggs, Scones • Fresh Roast Pork Mashed Potatoes Green Beans Head Lettuce With Russian Dressing Lemon Tarts • Oxtail Soup Mock Drumsticks Duchess Potatoes Mixed Spring Salad With Garlic Dressing Green Gage Plums Date Swirl Cookies	**11** Orange Juice Bacon, Coffee Cake • Roast Leg of Veal Oven Browned Potatoes Julienne Carrots Pineapple Salad With Celery Seed Dressing Fudge Sundae • Potato Chowder Chicken Salad Relish Plate Sponge Cake	**12** Fresh Stewed Rhubarb Scrambled Eggs, Toast • French Ragout Browned Rice Head Lettuce Salad With Roquefort Dressing Peach Pie • Chicken Barley Soup Assorted Cheeses and Cold Meats Bread, Butter Sandwiches Mixed Vegetable Salad With French Dressing Orange Sherbet Sugar Cookies
13 Stewed Prunes Soft Cooked Eggs, Toast • Roast Leg of Lamb With Mint Jelly Duchess Potatoes Broccoli With Hollandaise Sauce Grapefruit, Avocado Salad Pineapple Upside-Down Cake • Cream of Mushroom Soup Stewed Chicken Wings With Steamed Dumplings Cardinal Vegetable Salad Apricots	**14** Half Grapefruit Poached Eggs, Toast • Breaded Veal Chops Buttered Corn Whole Green Beans Tomato Salad Baked Custard • Oxtail Soup Smoked Sausage Glazed Sweet Potatoes Hot Wilted Greens Fresh Fruit Cup With Lemon Sherbet	**15** Tomato Juice Bacon, Biscuits • Baked Ham With Raisin Sauce Parslied New Potatoes Asparagus With Cheese Sauce Perfection Salad Peach Ice Cream • Split Pea Soup Meat Balls Stuffed Baked Potatoes Raw Vegetable Plate Royal Anne Cherries Sugar Cookies	**16** Apricot Nectar Scrambled Eggs, Muffins • Salmon Steak With Tartare Sauce Escalloped Potatoes Fresh Spinach, Lemon Lettuce, Tomato Salad With Mayonnaise Lemon Tarts • Potato Chowder Shrimp Wiggle, Toast Mixed Vegetable Salad With French Dressing Cupcake Chilled Apple Sauce Lemon Cookies	**17** Tangerine Juice Baked Eggs, Bacon Rings • Swiss Steak Mashed Potatoes Buttered Whole Carrots Fresh Pineapple on Water Cress Chocolate Sponge Cake • Cream of Tomato Soup Marconi Mousse Lyonnaise Green Beans Fresh Fruit Salad Cup Cakes	**18** Stewed Rhubarb French Toast, Sirup • Stewed Chicken With Homemade Noodles Buttered New Peas Tossed Vegetable Salad With Garlic Dressing Strawberry Sundae • Creole Soup Cold Assorted Meats Parslied New Potatoes Sliced Tomato Salad Chiffon Cake
19 Grapefruit Juice Poached Eggs, Toast • Calves Liver, Bacon Parslied New Potatoes Buttered Onions Tossed Vegetable Salad With Blue Cheese Dressing Strawberry Whip on Angel Food Cake • Scotch Broth Corned Beef Hash With Poached Egg Asparagus Tip Salad Apricots Chocolate Mint Cookies	**20** Tomato Juice Scrambled Eggs • Prime Beef Roast Mashed Potatoes Buttered Peas Head Lettuce Salad With Russian Dressing Baked Coffee Custard • Chicken Giblet Soup Fresh Vegetable Plate: Deviled Egg, Beets, Spinach, Corn Frozen Fruit Salad Sunshine Cake	**21** Sliced Bananas Shirred Eggs, Toast • Smoked Beef Tongue With Horseradish Sauce Creamed New Potatoes Cauliflower Pickled Beets Orange Bavarian Cream • Fresh Fruit Cup Italian Spaghetti With Meat Sauce Vegetable Relish Plate Pineapple Sherbet Sugar Cookies	**22** Orange Juice Bacon, Toast • Individual Chicken Pie With Biscuit Frozen Lima Beans Fresh Fruit Salad Chocolate Soufflé With Mocha Sauce • Grape Juice Meat Balls Stuffed Baked Potatoes Carrot, Raisin Salad Peaches	**23** Stewed Rhubarb Soft Cooked Eggs, Toast • Broiled Lake Trout With Lemon Duchess Potatoes Harvard Beets Health Salad Apricot Chiffon Pie • Mushroom Consommé Eggs à la King on Toast Buttered Peas, Carrots Tomato Salad Green Gage Plums	**24** Stewed Prunes Bacon, Danish Rolls • Roast Leg of Veal Oven Browned Potatoes Mashed Turnips Orange, Grapefruit Salad Sponge Cake • Creole Soup Cold Sliced Ham and Swiss Cheese Rye Bread, Butter Sandwiches Spring Salad With French Dressing Baked Rhubarb Ginger Cookies
25 Orange Halves Soft Cooked Eggs • Fried Chicken Mashed Potatoes Creamed Peas Sliced Tomatoes on Water Cress With French Dressing Vanilla Ice Cream • Chicken Noodle Soup Cheese Sandwich Loaf Fruit Salad on Water Cress Cooked Fruit Dressing Sunshine Cake	**26** Orange Juice Bacon, Toast • Fricassee of Veal With Fresh Vegetables Buttered Noodles Cabbage Slaw Apricots • Consommé Madrilene Meat Loaf With Barbecue Sauce Corn Pudding Asparagus With Mousseline Sauce Vegetable Relish Plate Strawberry Whip Ice Box Cookies	**27** Sliced Bananas Scrambled Eggs, Toast • Broiled Ham Slices With Broiled Pineapple Glazed Sweet Potatoes Buttered Cauliflower Molded Cherry Salad Jelly Roll • Chicken Rice Soup Creamed Dried Beef and Peas on Toast Head Lettuce With Parisian Salad Dressing Orange Sherbet Butterscotch Squares	**28** Tangerine Juice Poached Eggs, Rolls • Pot Beef Roast Oven Browned Potatoes Buttered Onions Vegetable Medley Salad Lemon Tarts • Cream of Mushroom Soup Cheese Soufflé With Spanish Sauce Buttered Beets Frozen Fruit Salad Chocolate Cake	**29** Stewed Prunes Canadian Bacon, Biscuits • Ham Loaf Potatoes au Gratin Buttered Asparagus Fresh Fruit Salad With Celery Seed Dressing Coconut Soufflé With Foamy Sauce • Creole Soup Chicken Timbales With Bechamel Sauce Buttered Peas Sliced Tomato Salad Pears	**30** Frozen Grape Juice Soft Cooked Eggs • Baked White Fish With Tartare Sauce Parslied New Potatoes Chopped Spinach With Sliced Egg Pickled Beet Salad Lemon Chiffon Pudding • Cream of Tomato Soup Tuna Fish Newburg Steamed Rice Tossed Mixed Green Salad With French Dressing Peaches Sugar Cookies
31 Tomato Juice, Bacon, Toast • Braised Short Ribs, Mashed Potatoes, Lyonnaise Carrots, Head Lettuce with 1000 Island Dressing, Apple Pie • Fresh Vegetable Soup, Cold Assorted Meats, Bread, Butter Sandwiches, Fresh Fruit Salad With Celery Seed Dressing, Oatmeal Cookies					

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1. what is a permanent filter?

A self-contained metal unit requiring no urn bags or filter paper. Preferably it is made of stainless steel.

The Tri-Saver system eliminates urn bags and filter paper. Prevents spoiled batches due to torn filter paper or rancid urn bags.

2. what should I look for?

The filtering surface should be so constructed that coffee grounds do not clog it. This may happen if ordinary mesh or screen construction is used.

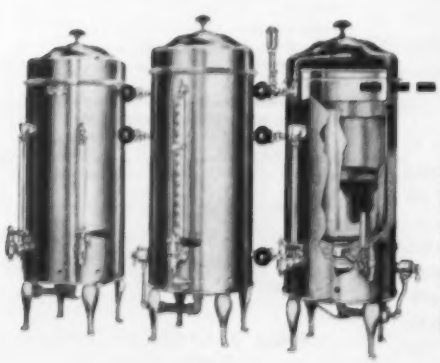
Ordinary mesh or screen surfaces trap coffee grounds, thus clogging the filter and making cleaning difficult. Flavor is affected.

Tri-Saver filter has no holes through it. Surface appears solid—yet water and coffee liquid will pass thru rapidly.

3. what is the Tri-Saver Coffee System?

It is an improved method of brewing *consistently* full-flavored crystal-clear coffee without urn bags or filter paper. Urns employed in the Tri-Saver system use patented permanent stainless steel filters with specially-constructed bottoms. Thousands have been in use for years, never clog, remain sweet and clean with ordinary care.

Cutaway view showing specially-constructed bottom of Tri-Saver filter. Filtering surface consists of two precision-perforated stainless steel plates welded together. The coffee liquid passes through holes in upper plate, then edgewise by capillary attraction into the holes of the lower plate and then into the liner below. Only the clear coffee brew with all the essential flavoring matter gets through. Rinsing provides thorough flushing by the same capillary action.



This permanent stainless steel Tri-Saver filter eliminates urn bags and filter paper. Coffee grounds cannot clog the filter with ordinary care. It is ready for next batch by simply rinsing under hot water faucet.

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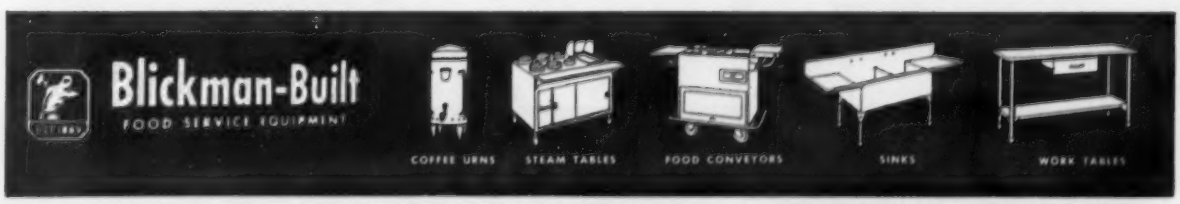

You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 26-28. Have you seen the Coffee Brewing Institute's new booklet on how to make good coffee, "Specialty of the House"? For a copy, write us on your letterhead

The Case of the Forty-Two Diapers

How long does a piece of linen last?

Laundry study uncovers some curious facts

VICTOR KRAMER

FORTY-TWO diapers per newborn patient per day seems an incredibly large number, but there were the figures, plain and unmistakable. In our report of a 17 month linen study of what we shall here call Alpha Hospital, a 650 bed general hospital in New York, we had not set out to inquire specifically into diaper usage. We had undertaken the survey to find out for budget purposes how many washings are obtained from each piece of linen. Purely a by-product of our main investigation, the revelation about the 42 diapers brought to light an hitherto undetected expense leak.

When we were asked by the executive director to carry out this special project, we set up a fact-finding apparatus with the cooperation of the laundry manager. Statistics were gathered on 16 selected items: spreads, pillow cases, sheets, patient gowns, bath towels, baby sheets, draw sheets, baby blankets, baby shirts, scultetus binders, face towels, bath blankets, pajama pants, wash cloths and T binders.

At the close of each working day, the items laundered that day were separated, counted and recorded. The findings over a 17 month period furnished the basis for our analysis. Here is what we found:

Table 1—Launderings Obtained per Item

Item	No. of Times Laundered
Spread, pillow case	150-200
Sheet, patient gown	100-120
Bath towel, baby sheet, draw sheet, baby blanket, baby shirt	55-95
Diaper, scultetus binder, face towel, bath blanket, pajama pants	35-50
Wash cloth, T binder	10-15

On the basis of the number of launderings, the estimated approximate life expectancy of these items would be about as follows:

Spreads, 32 months; pillow cases, 24 months; sheets, 20 months; patient gowns and bath blankets, 14 months each; draw sheets and bath towels, 12 months each; face towels, pajama pants, baby sheets and scultetus binders, six months each; baby blankets, diapers and baby sheets, four months each; wash cloths and T binders, two months each.

It was in the section on linen usage (pieces used per patient per day) that the interesting item on diapers appeared. The over-all findings on usage were:

Table 2—Linen Usage per Patient Day

Item	Pieces Used per Patient Day
Diapers	42
Baby sheets	11
Baby shirts, baby blankets	6
Draw sheets	1.8
Sheets	1.6
Pillow cases, face towels, bath towels	1.5
Spreads, patient gowns, wash cloths	1.
Pajama pants, bath blankets, T binders, scultetus binders	Less than 1/3 each

Forty-two diapers per infant day seem to be way out of line. Table 3 shows statistics on diapers at Alpha Hospital:

Table 3—Usage of Diapers at Alpha Hospital

Item	Quantity
Average number in circulation	10,401
New issued per year	27,950
Number washed per year	1,379,952
Number of launderings per year per diaper in circulation	132.7
Life expectancy—year	.37
Life expectancy—number of launderings per diaper	49
Need to issue to maintain 1 diaper in use	2.69
USAGE: Diapers per patient day	42.3

(*Continued on Page* 124)

The author is a laundry management consultant, New York City.

P.S. The Study Worked

To discover a wasteful linen practice is good. To correct it is better. What happened at Alpha Hospital after the 42 diapers figure was brought to light? The usage of diapers came down 25 per cent from 42 to 32 per patient day.

First, the number of diapers per bundle was cut from 50 to 40. Each nursing unit received 10 fewer diapers in its daily allotment. Then the educational process began. A few brief stand-up meetings with the nurses alerted them to be more careful. Periodic recheck of the balance between demand and supply, a careful eye on week-end needs, and specific attention to other details all contributed to the improvement.

The box score now:	April	May	June
Diapers Laundered	114,080	98,120	92,840
Newborn Days	2,860	2,858	2,870
Diapers per Patient Day	39.9	34.3	32.3

Result: 20,000 fewer diapers washed per month. A genuine dollar savings to the hospital.

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Like all *Finnell Fast-Acting Cleansers, Sanax* is specially designed for the greater speed of machine-scrubbing, and works as effectually in a *Combination Scrubber-Vac* as in a *Conventional Scrubber-Polisher.* And because *Sanax* is processed from pure vegetable oils, it's *safe for all floors.*

Find out how you can simplify and reduce the cost of caring for waxed floors. *There's a Finnell Floor Specialist nearby* to help you choose the waxes and cleansers that are *exactly right for your needs. Finnell* makes a complete line, so you can depend on unbiased advice. In fact, *Finnell makes everything for floor care!* For consultation, demonstration, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1402 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

- **A mild liquid wax-soap for machine-scrubbing or damp-mopping waxed floors**
- **Leaves a lustrous anti-skid protective finish**
- **Highly concentrated . . . economical to use**

FINNELL SYSTEM, INC.

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BRANCHES IN ALL PRINCIPAL CITIES

(*Continued From Page* 122)

The 42 diaper figure showed up one of the weak spots. Why so many diapers? On warm days nurses were wiping their moist brows with them. Then zoom!—into the soiled diaper bag. Diapers also doubled, we found, as bibs, bath wrappers, pads to keep drafts away from the cribs, mopping cloths and what not. Further, the fact that each newborn patient used 11 sheets and six baby shirts per day needed looking into. A reevaluation of procedures by the administration and the obstetrical service was indicated, with perhaps a reorientation job on nurses and employes of the maternity department. They needed to be educated on the high cost resulting from such excess usage.

Also, it seemed that the usage of one spread per patient day might be high. In theory, the standard at Alpha Hospital is four spread changes a week: on Tuesday, Thursday, Saturday and Sunday. In practice, as the study showed, there are actually seven spread changes a week. This also called for a review of standards by the administration to determine whether a clean spread per patient day is justified or not.

Another high usage figure was that for T binders. Our findings showed only 11 launderings per T binder. To keep one binder in use annually, the hospital issued 6.7 binders. There is a high rate of loss on this article; surgical patients often wear them as they go home. However, the hospital feels there is not much to be done about this particular loss; it will simply continue to be absorbed in the daily cost. We know another hospital which charges a nominal sum to each patient for the T binder when issued. The binder then becomes the patient's property. But we do not consider this good public relations.

On the other hand, the 1.6 sheets used per patient day did not appear to be at all out of line. One sheet is changed for each patient per day, the top one being switched to the bottom and the bottom one going to the laundry. The 0.6 is accounted for by incontinent patients, extra sheet changes for some medical, surgical or obstetrical cases, and sheets for the live-in staff.

WHAT HAPPENS TO WASH CLOTHS

It is notable that sheets ordinarily survive for 20 months while wash cloths last for only two, a fact which bears no relation to relative fabric strengths or washing procedures. The wide variations in linen life or "mileage" between different kinds of pieces derive from other sources. In Alpha Hospital, the laundry uses approved washing formulas which conserve linen life.

The striking difference between the two items is due to pilfering, misuse or unexplained disappearance of the smaller article. Wash cloths (towels also) have a way of ending up in wastebaskets or soiled dressing cans. At any rate, here again is a slack spot that needs some thought, study and tightening. Every hospital administrator knows that over-all costs are built up by a thousand little undetected leaks.

For a valid interpretation of the foregoing facts, it would be better to have similar figures on usage in other hospitals, which are lacking. However, some comparative statistics on the cost of new linen per patient day are significant. Table 4 shows a prevailing cost of 25 cents per patient day for linen replacement (in the eight hospitals covered), whereas

Table 4—Comparison of Annual Cost of New Linens at Eight Voluntary Hospitals

Hospital	Number of Beds	$ New Linen Issued Into Circulation	Cost of Linen Replacement per Patient Day
Alpha	650	$ 32,204	0.173
B	260	26,732	0.324
C	970	56,003	0.250
D	120	9,827	0.244
E	150	11,214	0.240
F	1520	101,243	0.231
G	160	10,512	0.173
H	230	11,708	0.167

Table 5—Analysis of Linen Usage Reported by a Massachusetts Hospital

Item	Average In Circulation	Issued/ Year	Pcs. Issued to Maintain 1 In Circulation	Life Expectancy per Piece in Years
Diapers	5182	4351	0.84	1.19
Patient gowns	859	723	0.84	1.19
Pillow cases	1360	861	0.63	1.58
Sheets	2113	869	0.41	2.43
Bath towels	1063	1164	1.10	0.91
Hand towels	982	1400	1.43	0.70

Alpha Hospital spends less than 18 cents per patient day for new linens. One large voluntary hospital reported to us, the fiscal year ended June 30, 1954, with 285,696 patient days, a new linen cost, including uniforms, of $58,576.35, or 20½ cents per patient day for linen replacement cost.

There is good reason Alpha Hospital is among the three whose linen replacement costs are lowest. Its linen control system is efficient. Circulating inventories are carefully taken at quarterly periods; closet levels are frequently checked. The administration keeps a constant watch over the distribution and allotment of clean linen. This study was not requested for the purpose of effecting drastic reforms; none was needed. No serious abuses were exposed. And yet, even in this well run laundry-linen department, our investigation showed that there were some areas where tightening could be done and improvements made in the system. Alpha Hospital will be able to pare down its new linen costs still further, without diminishing its high standards.

A Massachusetts hospital disclosed a vastly different situation, as seen in Table 5.

The Massachusetts hospital has fewer beds, a different type of building structure, stricter controls and other physical features which result in a better experience. Comparing the figures of one hospital with those of another may lead to wrong conclusions, unless all the variable factors are weighted.

This study of linen life expectancy —while not a definitive analysis—has served one hospital as a helpful guide in determining how many of each item to buy, how many to keep new in reserve, and how many to approve for issue into circulation. It does not in any way represent an ideal standard. It is, rather, a laboratory report on one clinical case history, true for one 650 bed hospital. Regarded in this light, it furnishes a basis of comparison for similar institutions, and may suggest some ideas to other hospital administrators. Above all, it pinpoints the need for more extensive studies, based on further data concerning linen control practices now in effect.

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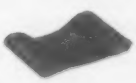
DICTABELT  *exclusive record of the Dictaphone*

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They Still Prefer the Linen Pack System

The cart exchange system has its merits but this hospital decided to stick with its linen packs because the pack system permits a higher standard of care

NEIL McGINNISS

Above: Housekeeping maid with discharge pack preparing to make bed and prepare room for new admission. Below: Linen room supervisor, delivering to patient area an exchange cart loaded with loose linens.

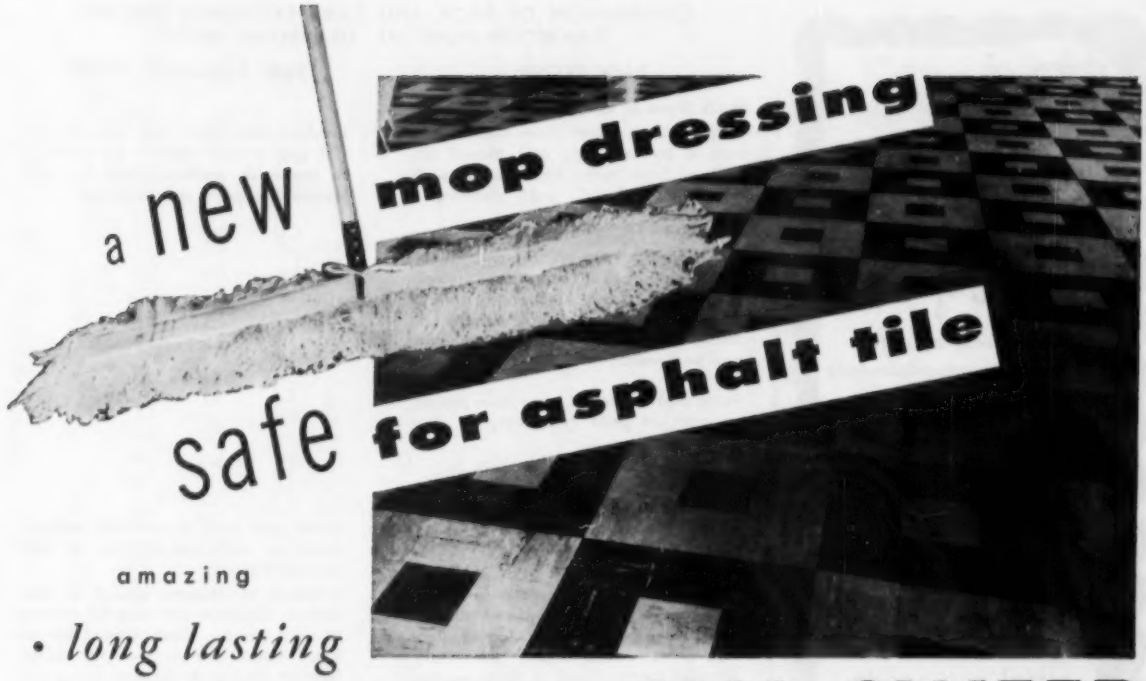
IN HIS search for greater efficiency and improvement in economies of operation, the administrator of the modern hospital constantly keeps an eye out for possibilities of methods improvement and work simplification in all the departments which make up his organization. Merely stretching the dollar and producing the greatest amount of work with the slightest amount of effort, however, is not the ultimate goal of the successful administrator. His ultimate goal is the best possible care of the patient.

With these considerations in mind, the administration and department heads at Oakwood Hospital, Dearborn, Mich., periodically survey various activities and systems in daily use. Particular attention is devoted currently to those systems which have not been modified since their inception on the opening day of the hospital in January 1953.

Recently a study was made of the merits of the pack system of linen delivery in use at Oakwood against the merits of the cart exchange system of linen delivery, which has been gaining in popularity in many hospitals. (See page 130.) It may be mentioned that, before the study was completed, nursing and housekeeping obviously leaned toward the pack system. Administration and laundry, however, expected a fairly cut and dried decision in favor of the new cart exchange system. Several hospitals in the area had changed over to this new method of delivery and were quite pleased

(*Text Continued on Page* 132)

Mr. McGinniss is administrative resident, Oakwood Hospital, Dearborn, Mich.



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COMPARISON OF PACK AND CART EXCHANGE SYSTEMS, OAKWOOD HOSPITAL, DEARBORN, MICH.

PACK SYSTEM	CART EXCHANGE SYSTEM
Work Done in Laundry Finished linen taken from table near mangle by two girls and placed on shelves. Later taken from shelves and rolled into "daily" and "discharge" packs. "Daily" pack consists of one sheet, draw sheet, pillow case, hand towel, bath towel, wash cloth and patient gown. "Discharge" pack consists of above items plus one mattress pad and bedspread. Packs and additional loose linen placed on cart just prior to delivery to each station.	Finished linen taken from table by one girl and placed directly on carts up to standards predetermined for each station. No packs are prepared.
Delivery Equipment Six carts for all delivery.	Seven carts plus 16 specially designed trucks for exchange delivery to eight nursing stations.
Delivery Morning delivery to delivery room, nurseries, obstetrics floor, central supply. Afternoon delivery to 2d floor (operating room, x-ray, laboratory, physical therapy) and to three medical and surgical floors. All deliveries made by transporting loaded carts to linen closets at each station. Linen is removed from cart and placed on shelves in closet, bringing linen supply up to predetermined standards at each station. Cart with surplus linen then returned to laundry for reloading. The majority of trips to the floors are made by two girls together. Each takes a cart and each delivers to a different station on the same floor. In the utility rooms in back of the nursing stations, cabinets built in the walls especially for this purpose are used for linen storage. Cabinets at one end of the room are used for one wing, and those at the other end are used for the other wing.	Schedule of delivery, similar to other system. Separate cart used for delivery to each station. Carts loaded for patient floors transported to former blanket cupboards located across corridor from nursing stations. Loaded cart is exchanged for cart delivered on previous day. Used cart transported back to laundry to be loaded for next day's delivery. One girl makes all deliveries.
Sunday Double to triple standards delivered to all stations on Fridays to carry them over the week end.	Saturday delivery to nursing stations for Saturday evening and Sunday. Amounts in excess of daily standards. Early Monday morning delivery to nursing stations as well as regular Monday afternoon delivery.
Work Done on Nursing Unit First thing in the morning, aide on each wing loads "daily" packs on cart. Aide then distributes packs room by room as she moves down the corridor. At the same time in each room the aide gives early a.m. care and passes wash water. On the return trip, each patient's water pitcher is picked up to be filled with fresh drinking water, and wash basins are emptied. Housekeeping maid takes "discharge" pack as needed from utility room linen closets to patient's room.	Two aides move linen cart from blanket cupboard down one wing and back, then down another wing and back. As they proceed down each wing, the aides distribute to each room quantities of linen sufficient for each patient's daily needs. The cart is then returned to the blanket cupboard. Each aide makes an additional trip down her wing, giving early a.m. care and picking up water pitchers. Housekeeping maid takes linen needed for discharge from cart in blanket cupboard to patient's room.

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with the results. Also, a great deal of material has appeared in the literature lately, explaining numerous advantages of such a system.

It was decided that for a two-week period the cart exchange method of linen delivery would be tried at one nursing station, which controls two wings of a patient floor serving approximately 31 patients. Throughout the remainder of the house the pack system would be continued.

A study was then made in several steps. First, a record of delivery of linen throughout the whole hospital by the system currently in use was made for one day. Recorded were all stations to which linen was delivered, time the carts left the laundry, time the carts returned, and total time in minutes used expressly for linen delivery.

Second, a record was made of time used for delivery and exchange of carts at the one nursing station that was trying out the new method. Using this as a base, we estimated the total time in minutes used for delivery by the new method for the whole hospital.

Third, a time and motion study was done of a complete operation consisting of taking loose linen from the mangle, preparing packs, and delivering one day's standard of linen to one nursing station, using the current methods.

Fourth, a time and motion study was done of a complete operation consisting of taking loose linen from the mangle, placing it on a cart, and delivering one day's standard to one nursing station, using the exchange method.

Fifth, a record was made of the total time in minutes consumed in making linen packs in one day.

Sixth, a study was made of the operations involved and the time in minutes consumed in the delivery of daily packs of linen to patients' rooms on one nursing station one morning.

Seventh, a study was made of the operations involved and the time in minutes consumed in the delivery of daily quotas of loose linen to patients' rooms on one nursing station one morning.

The chart on page 130 is an analysis of the two methods of linen delivery used during the test period.

At the conclusion of the two-week trial, it was readily apparent that the cart exchange system would save the hospital one laundry employe's salary or a little less than $2000 per year.

Savings in labor time in terms of minutes per day, using this method, was found to be thus:

In loading carts directly from mangle table:	112
In fewer steps in laundry:	128
In preparing no packs:	152
In delivery to floors:	112
Total	504

In the light of this analysis, it may be surprising to some that it was unanimously agreed by the director, assistant director, director of nursing and administrative resident, who conducted the survey, to continue the system of delivery of linen packs to the nursing stations, which is in use at present.

The reasons for this decision were enumerated in a summary report of the survey as follows:

1. It is the philosophy of Oakwood Hospital that everything possible should be done to provide the best and most efficient care possible for the patient. Some complications, additional physical work, and additional

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steps would be added to the nursing and housekeeping staffs with a change in systems. At present the hospital desires not to reduce any costs at the expense of smooth flowing, well organized nursing care of the patient.

2. The present system of passing linen to patients in the morning combines in one trip delivery of linen and early a.m. care. The cart exchange method requires an extra trip to give a.m. care.

3. In the present design of Oakwood Hospital, there is available only one area per nursing station which is centrally located and large enough to accommodate a cart of adequate size to carry a nursing station standard of linen. This is the present blanket cupboard. It is nowhere near as handy to personnel working on one of the two wings of a nursing station as is the present linen closet. Its use, therefore, would result in many extra steps for members of the nursing and housekeeping staffs.

4. It would prove extremely costly to tear out the metal shelving in the cabinets presently used to store linens in the nursing station utility rooms. In addition, these linen storage areas are too small to accommodate a large cart. It would not be feasible to purchase 32 smaller carts, two for each wing. The laundry would be crowded, and use of so many carts would in no way save delivery time.

5. A linen pack presents a neat, efficient appearance to the patient. Over-the-arm delivery of six or eight pieces of loose linen, often from a distance down the corridor, is cumbersome to the aide or maid and such linen is likely to be untidy. There is much greater possibility that linen may be dropped on the floor, either in transportation or after delivery to the room.

6. All laundry carts observed were rather difficult to maneuver. It is much easier for the aide to push a small cart down the corridor.

7. Blanket cupboard door is left unlocked so that it is more readily accessible. A tendency to leave the door open was observed. Even with special compartments, a linen cart loaded with loose linen tends to become messy and unruly. Not only do the carts spoil the neat appearance of the nursing unit, but they seem too easily available to visitors making use of the corridors.

Laundry manager checking quota of packs with a linen room helper.

In brief, Oakwood decided to stick with the system which, it was believed, would enable the nursing department to function most smoothly and give the highest quality of care to the patient. After thorough study, we found that it was not the least expensive method insofar as laundry labor costs only were concerned, but it was by far the most satisfactory method insofar as the over-all picture was concerned.

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Control Means More Than "Low Costs"

(*Continued From Page 74*)

any emergency or unusual situation that may occur.

5. *Methods and time of scheduling special procedures,* especially surgical, can be controlled, except for emergency and unusual situations.

6. *Visitors.* We are seeing a change in hospitals' attitudes concerning visitors. Leniency and a spreading out of visiting hours have been demonstrated in certain situations as an asset to personnel time as compared with the time involved to enforce previous restrictions.

7. *The use of budgets* for nursing service is a valuable mechanism for planning and for control of nursing costs.

8. *The use of cost analysis,* like budgets, is a valuable asset in controlling costs.

There are many examples which may be added to this list.

RESPONSIBILTY FOR COST CONTROLS

Who should take the initiative in matters of nursing service cost controls? As head of the department, the director of nursing service should be more interested than anyone else. In all fairness to her, I believe she is the most interested. In fairness also, I must say that she is not always administratively able to take the initiative. There may not exist the permissive climate in which she can execute such a program. On the other hand, she may need over-all administrative guidance, assistance and encouragement to proceed properly in a profitable and businesslike manner.

The responsibility is, then, a shared one. It must be approached by both the department head and the hospital administrator. What is more, it will involve other departments because of the nature of the nursing service department and its relationships throughout the whole hospital. Everyone must have a common acceptance of purpose, method and economical modes of operation.

The department head, however, must furnish data in a pertinent, concise form. In the case of the nursing service such data include information on personnel time, functions, equipment used, guidelike procedures, and other similar matters suggested in the previous review of the three major cost control areas. The volume of such information is not the important element. Its pertinence is.

The value of analyzing operations with the objective of controlling costs is reflected not only in the dollar sign. Several other potential benefits can accrue to the hospital, such as the following:

1. It is a source of obtaining objective data on the operation of the department.

2. It delineates the weaknesses and strengths of the administrative procedures.

3. It provides guideposts for improving methods of operation.

4. It gives direction to the preparation of a more realistic budget.

5. It is directional to inservice training needs.

6. It provides a measurement of the type and amount of services required.

7. It tests the reliability of the functional organizational plan.

In general, what kind of changes may result from a cost-conscious administrator and department head? There may be changes in salary scales, work loads, assignment of duties, work distribution, qualification of workers, equipment, methods of procedures. Of equal importance, one must recognize that there may be no change at all—not even in total cost!

The size and type of the hospital are no limiting factors in undertaking a project for the control of costs of nursing service. In every instance this department accounts for a large share of total hospital expenditure. In every instance it is the largest department or unit of the establishment.

A word of caution is in order. All hospital objectives are concerned with human factors. Therefore, one cannot realistically reduce all elements in administrative or business evaluation to cold figures, percentages and ratios. Statistical and financial data should be used to substantiate, explain or define certain measurable elements and should serve as a guidepost to supplement human action and judgment.

This is not the first time that this subject has been discussed, nor will it be the last time either. Some methods reported at various meetings that have proved useful in controlling nursing service costs which might be of interest are as follows:

1. By establishing joint conference committees between nursing and administration.

2. By furthering, through education, the value of the team concept of nursing.

3. By having administration make an effort to explain finances to the medical staff.

4. By a restudy of procedures.

5. By creating an awareness on the part of nurses of breakage—starting at the student level.

6. By determining what constitutes an emergency.

7. By regulating the timing for operating room, laboratory, rounds, admissions and discharges.

8. By minimizing personnel turnover.

9. By establishing specialty teams for I.V. and preoperative work.

10. By use of more clerks.

11. By use of more labor saving devices, such as invalid lifts.

12. By having written hospital regulations for use of the medical staff.

13. By obtaining economy of supplies through a simplification of procedures.

14. By the establishment of job descriptions and specifications.

15. By restricting admissions to hours when most of the nursing staff is present.

16. By grouping of patients—keeping those most acutely ill together. Same for convalescents.

17. By establishing recovery room service.

18. By better planning of facilities.

19. By establishing standards of supplies for each ward or unit, such as for linen and drug deliveries.

20. By standardization of doctors' requirements.

21. By better orientation of interns and residents.

22. By standardization of drugs on floors through the use of a formulary committee.

23. By establishing a routine time for doctors' visits and dressings.

24. By studying the effect of visiting time on nursing time.

25. By preventing overlapping of functions.

26. By using the same kind of equipment in all units.

27. By standardization of inventory.

28. By establishing two-way communication systems.

29. By use of piped-in oxygen.

30. By use of evaluation questionnaires.

31. By use of addressing machine.

32. By establishment of a health program for all personnel.

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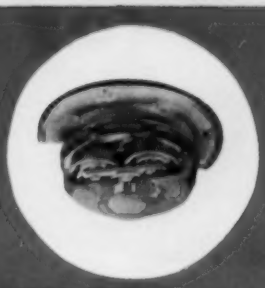

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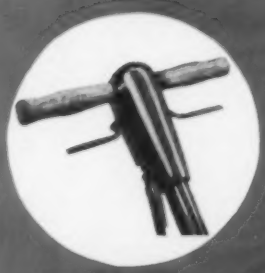

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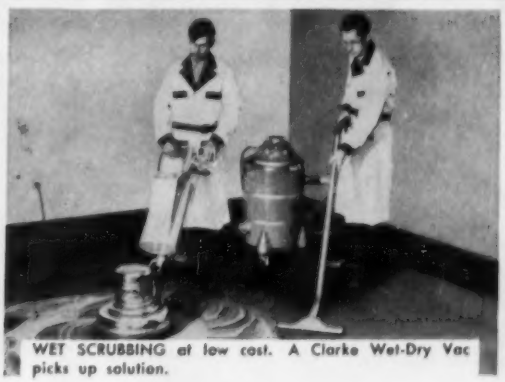

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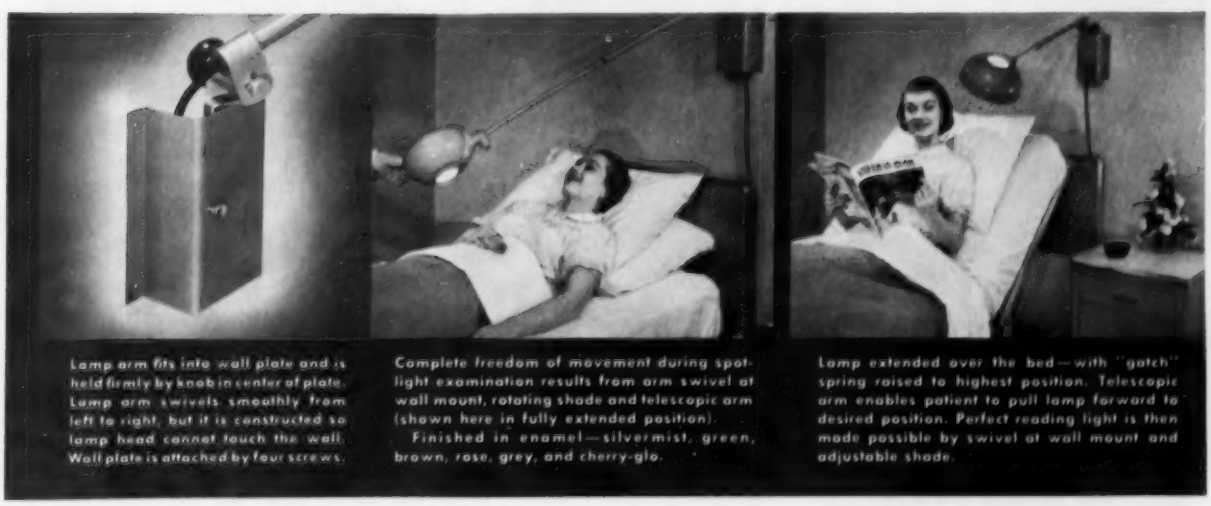

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NEWS DIGEST

Investigate Write-Off of Bills at Jersey City Medical Center . . . Provident Hospital Denies Mismanagement Charge . . . Chicago Hospitals Consider Merger . . . Iowa Hospitals Await Supreme Court Decision . . . Missouri Names Officers

Investigation Reveals Write-Off of Bills Totaling $3,648,595 at Medical Center

JERSEY CITY, N.J.—The Jersey City Medical Center here was used by politicians as a source of political favors and graft, it was revealed last month in the report of a two-year investigation of city funds.

Samuel A. Larner, appointed by the superior court to investigate charges of unlawful disbursement of public funds by previous city administrations, said the late Mayor Frank Hague and his successors gave away more than $3 million in free hospital care for political beneficiaries, many of whom were able to pay their own bills.

In many cases, the medical center failed to collect hospitalization insurance payments on behalf of patients whose bills were written off as political favors, the report said.

In some cases, insurance payments were given back to the patients whose bills had been canceled, it was reported.

A total of $3,648,595 in hospital bills was canceled during the years 1945 to 1952, Mr. Larner reported.

The report also disclosed the existence of a dummy corporation established by a local politician to profit from sale of oxygen and intravenous solutions to the hospital and its patients.

In February 1952, it was reported, the hospital agreed to rent five oxygen tents from the dummy corporation, which earned $10,000 in rental fees in 1952 and 1953.

The dummy corporation also figured in the purchase of $60,000 worth of intravenous solutions, it was revealed. A legitimate supplier sold the solutions to the hospital through the corporation, the report said; later the supplier paid a 5 per cent commission to a politician who controlled hospital purchases.

Canceled bills for political favorites were marked with code numbers, according to the name of the politician requesting the charge-off, the Larner report said. Bills were canceled by charging off accounts as "uncollectible" or "free service," though many of the beneficiaries were prominent public officials well able to pay their obligations.

"Close association with political activity was the prerequisite for free hospital service," the report said.

The political write-offs reached a peak in 1953 under Mayor John V. Kenny, successor to the Hague regime. During this period, cancellations totaled $1,049,119, it was reported.

Name Florida Officers

ST. PETERSBURG, FLA. — At its annual meeting here, the Florida Hospital Association elected new officers to serve with President Robert B. Eleazer Jr. of St. Luke's Hospital, Jacksonville. President-elect is Ben P. Wilson of Munroe Memorial Hospital, Ocala; secretary-treasurer is Sister Josephine Marie of St. Mary's Hospital, West Palm Beach. Pat N. Groner, administrator of Baptist Hospital, Pensacola, and past president of the association, was elected delegate to the house of delegates of the American Hospital Association. Steve F. McCrimmon of Doctors' Hospital, Coral Gables, is alternate delegate.

Left to right: Ben P. Wilson, Sister Josephine Marie; Robert B. Eleazer Jr.

Provident Hospital Denies Charge of "Mismanagement"

CHICAGO. — Dr. John C. Troxel, chairman of the board of trustees of the Provident Hospital here, last month denied a public charge of "mismanagement" made by a physician who resigned from the staff.

Dr. N. O. Calloway said in a letter of resignation to the hospital board that the house staff and nurses failed to carry out doctors' orders, that some department heads were not qualified, and that the hospital training programs were inadequate.

"Conditions at Provident are neither as bad as Dr. Calloway says they are, nor are they as good as we would want them to be," Dr. Troxel said in reply.

He indicated the resignation was occasioned by the board's failure to elevate Dr. Calloway from an attending to a consulting staff appointment, as he requested, and by dissatisfaction with the pattern of racial segregation at the hospital.

Commenting on two other resignations from the Provident staff, Dr. Troxel said one of these was entirely unrelated to Dr. Calloway's charges, and the other physician had not been a member of the staff for five years.

New England Assembly

BOSTON.—The New England Hospital Assembly will hold its 33d annual meeting at the Statler Hotel here, March 26 through 28. "How to do it" instructional sessions, from which some thousand persons had to be turned away last year, will again be a feature of the assembly. Dr. Paul Dudley White, heart specialist, Irving Gilman of the Institute for Motivation, Raymond P. Sloan, president, the Modern Hospital Publishing Co., and Ray E. Brown, president of the American Hospital Association, will be among the speakers.

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Iowa Hospitals and Doctors Await Decision of State Supreme Court

DES MOINES.—Following the Iowa Hospital Association's decision to appeal the district court ruling that hospitals are practicing medicine illegally, both sides in the long standing hospital-physician dispute here settled down last month to await a decision by the state supreme court on the legality of hospital arrangements with radiologists and pathologists.

Hospital association attorneys indicated the appeal might take as much as a year and advised hospitals that their arrangements with specialists need not be adjusted to conform to the district court ruling as long as the case is under appeal.

The district court ruled against the hospital association last November 28 in favor of the State Board of Medical Examiners, state society of pathologists, and state medical society.

Commenting on the decision and the case, the *Des Moines Register* said last month: "Both sides insist they are acting in the interests of patients as well as their own group. When the fight gets hot, as in Iowa and Ohio, both sides sometimes charge the other with greed, bad faith, and ignoring the interests of patients.

"This is unfortunate, because, however the feud comes out, close cooperation between doctors and hospitals is essential.

"A doctors' victory would be more disruptive of present ways of doing things, but many doctors feel it is necessary to ensure medical control of medical practice.

"Yet both sides agree that only individual doctors, not institutions or lay administrators, can rightfully make a diagnosis and order or administer treatment."

Tri-State Assembly to Meet

CHICAGO. — The Tri-State Hospital Assembly has chosen "Hospitals and Human Needs" as the theme of its annual meeting in 1956. The assembly will be held April 30 through May 3 at the Palmer House here. Among subjects to be considered at general sessions during the conference will be: "Blue Cross and Hospitals Working Together," "Legal and Insurance Aspects of Hospital Care," "Integrating Service for Long and Short-Term Patients," and "Communications."

Chicago Hospitals Considering Merger

CHICAGO.—In spite of denials by officials of both hospitals that any agreement had actually been completed, the report persisted here last month that the St. Luke's and Presbyterian hospitals would merge, establishing joint operation in an expanded Presbyterian Hospital plant on the west side.

Under the reported plan, the St. Luke's Hospital buildings on the near southeast side would be given up by the hospital.

Joseph P. Bent, chairman of the St. Luke's board of trustees, said the merger was just one of several courses of action the St. Luke's board had considered; others were moving to another site, or rehabilitating the existing plant.

A 180 bed addition to the 400 bed Presbyterian Hospital is under construction, it was reported. St. Luke's Hospital at present has 550 beds. Under the merger plan as reported, a further addition to the Presbyterian Hospital plant is contemplated.

St. Luke's Hospital (above) and Presbyterian Hospital (below) are considering plans to establish joint operation.

Mayor Intervenes in Kings County Dispute

NEW YORK.—A ruling by the mayor delayed action on an order to dissolve the county division of the medical staff of Kings County Hospital Center, Brooklyn, following a dispute between the staff's university and county divisions last month.

Mayor Wagner's order postponed action on the staff reorganization recommended by Hospital Commissioner Basil C. MacLean and approved by the city board of hospitals from January 1 to March 1, it was reported.

The county division, consisting of practicing physicians in the Brooklyn area who are not members of the state university college of medicine, said the reorganization would prevent proper development of physicians and surgeons practicing in Brooklyn.

About two-thirds of the hospital's 3200 beds have been controlled by the university division, Dr. Howard W. Potter, dean of the college of medicine, said.

Dr. Potter indicated more beds were needed by the university division because of an increase in the number of medical students.

The county group felt its members needed additional beds to permit proper development of their practices. Approximately 80 per cent of the university division's staff are practicing physicians in the Brooklyn area, Dr. Potter reported.

The order to dissolve the county division and reorganize the staff under university supervision was recommended by Dr. MacLean as the solution to an "intolerable situation" culminating five years of "squabbling" between the staff's two divisions.

The reorganization plan was approved by the board of hospitals last October and resulted in protests from the county division, headed by Dr. Arthur Fankhauser. The decision was described as "arbitrary and dictatorial."

Postponing action on the reorganization order, Mayor Wagner said he was not "challenging the professional judgment" of the commissioner and board of hospitals but felt the postponement was needed "to establish a procedure under which members of the county division will be asked to become members of the university division if they so desire."

The reorganization plan had included a provision under which members of the county division of the staff could join the university group and remain on the hospital staff.

Missouri Hospital Group Elects Officers; Studies Doctor-Hospital Relations

ST. LOUIS.—The Missouri Hospital Association installed Bertha Hochuli, R.N., as president at its annual convention here December 14. Miss Hochuli is administrator of the Boone County Hospital, Columbia.

At a session on physician-hospital relations, Dr. Albert N. Snoke urged hospitals and doctors to work out their own differences. Solutions should be worked out with full consideration of the patient's welfare, he said. Dr. Snoke, president-elect of the American Hospital Association, also reviewed the recent Iowa district court decision requiring hospitals to lease certain facilities to doctors.

Harry L. Thomas, attorney for the Kansas City Area Hospital Association, pointed out that the Iowa decision was not applicable in Missouri. Missouri law has long established that hospitals are not "illegally practicing medicine" when they employ physicians and bill patients for their services, he said. Mr. Thomas also reminded the group that conflicts which are taken to court may be carried all the way to the Supreme Court, in which case both hospitals and doctors are losers, regardless of who wins the final decision.

At the Missouri hospital banquet, left to right: Dr. Frank R. Bradley, Mary C. Schabinger, R.N., guest speaker, Bertha Hochuli, new president, and Horace L. Burgin, retiring president.

A public relations man, Martin Quigley, emphasized that the public eventually pays the hospital bill, directly or indirectly, and therefore should have a voice in the operation of the hospitals. Mr. Quigley criticized the recent Ford Foundation's grant to hospitals as indiscriminate. He said it would have been better if the foundation had channeled its funds to hospitals "that showed some imagination" in trying to meet public health needs and problems.

Dr. Hollis N. Allen, a St. Louis pathologist, accused Missouri's hospitals of "leaving an open wound" in a controversy between Blue Cross and Blue Shield last summer, and warned that cooperation does not result when the party with the biggest weapon takes advantage of its position.

A plea for recognition of the general practitioner on hospital staffs was voiced by Dr. Charles E. Martin, president-elect of the Missouri Academy of General Practice. He claimed that general practitioners handle 80 per cent of the patients and yet find themselves relegated to the position of treating minor ailments and acting as "referral agents for the hospital and its staff of specialists." Dr. Martin said general practitioners want to have their work observed and evaluated so that they may be judged on the basis of individual competence.

Speaking on "Missouri's Health Needs," Dr. Victor B. Buehler, president of the Missouri State Medical Association, pointed out that the basic Medical Practice Act, enacted in 1850, was obsolete. He spoke favorably of the efforts of the joint committee on hospital-physician relations of the Missouri Hospital and Missouri State Medical associations to work out new standards of health care.

Marian Sheahan, R.N., associate director of the National League for Nursing, emphasized that the public is calling for better trained nurses today. Discussing the subject, "Looking for Improved Patient Care," Miss Sheahan stressed care of the whole patient.

A panel on administrative teamwork described the ethical and legal responsibilities of nurses, nurse educators, hospital administrators, and medical record librarians. A practical nurse program which has been worked out in the Toledo area was described as an illustration of successful teamwork.

The new president of the Missouri association, Miss Hochuli, was chosen president-elect at last year's convention. She is also treasurer of the Missouri State Nurses' Association.

Other officers, elected at the hospital association's business meeting and installed at the annual banquet, are: president-elect, Harry E. Panhorst, associate director, Washington University Clinics, St. Louis; first vice president, G. O. Lindgren, Trinity Lu-

Joachin Memorial Clinic, EENT Hospital, **New Orleans, Louisiana**
Architect: Jules K. de la Vergne
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This noise-quieting ceiling meets strict sanitary standards

Ease of cleaning was a major consideration in selecting materials for the new Joachin Memorial Clinic at New Orleans' Eye, Ear, Nose, and Throat Hospital. To meet strict sanitary standards, glazed wall tile, resilient floors, and acoustical ceilings of Armstrong Arrestone were installed throughout the building.

Arrestone is a metal-pan type material with a baked-on enamel finish that's readily washed or repainted. As a further aid to hospital maintenance, individual units of an Arrestone ceiling can be quickly removed and replaced to speed repairs on concealed wiring, pipes, or ducts.

Soaks up noise . . . Unusually high in acoustical efficiency, Arrestone soaks up as much as 85% of the sound that strikes it, helping to provide the quiet so necessary to recuperation.

Completely incombustible . . . Because Arrestone consists of a metal pan backed up with a mineral wool pad, it is rated incombustible and meets all fire-safety regulations.

High light reflection . . . Arrestone's white enamel finish reflects 75% of the light that strikes it without causing annoying glare. Contact your Armstrong Acoustical Contractor for a free estimate and details on Arrestone and the entire line of Armstrong Acoustical Materials.

New, free booklet, "Quiet at Work," shows how sound conditioning can work for you by increasing efficiency and comfort. For your copy, write Armstrong Cork Company, 4202 Union St., Lancaster, Pa.

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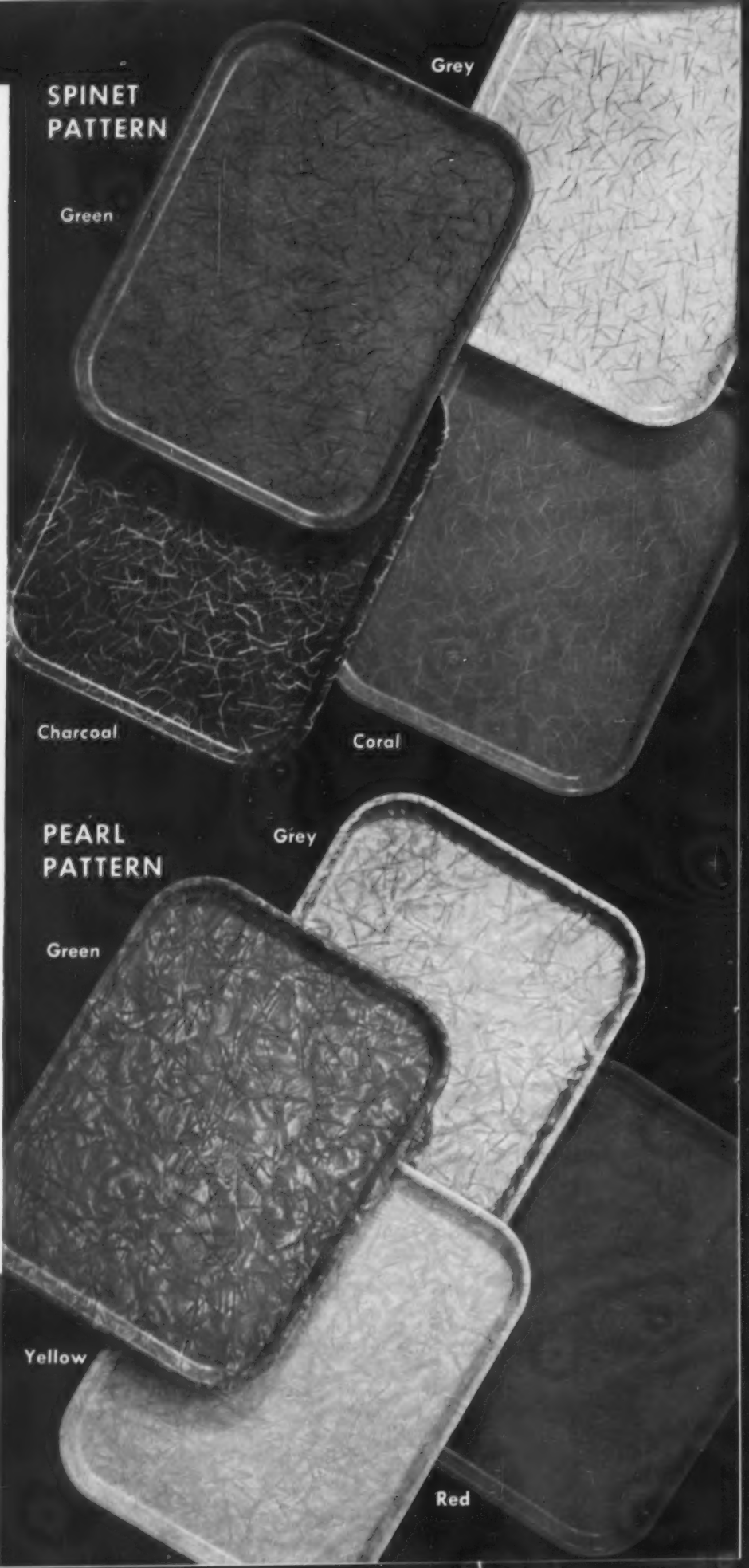


theran Hospital, Kansas City; second vice president, Ted O. Lloyd, Phelps County Hospital, Rolla, and secretary, Irene F. McCabe, St. Louis. The Rev. E. C. Hofius, Lutheran Hospital, St. Louis, was reelected treasurer for the twelfth consecutive term.

Rozene McClelland Heads Missouri Record Librarians

ST. LOUIS. — The Missouri State Association of Medical Record Librarians installed Rozene McClelland, R.R.L., of Kansas City General Hospital Number 1, as president at its annual convention here.

Elected to serve with Mrs. McClelland are: president-elect, Lydia Petrich, R.R.L., Kansas City General Hospital Number 1; vice president, Miriam Landis, R.R.L., Christian Hospital, St. Louis; secretary, Sister Marie Eugenio, S.S.M., R.R.L., St. Mary's Hospital, Jefferson City; treasurer, Nancy Gebhart, R.R.L., City Hospital Number 1, St. Louis; directors, Harry Berg, M.R.L., Robert Koch Hospital, St. Louis, and Marjorie Boulton, C.R.L., Jewish Hospital, St. Louis.

Nursing Home Officers

ST. LOUIS. — New president of the Missouri State Nursing and Allied Homes Association is Gladys Davis, R.N., of Davis Nursing Home, Springfield. Also elected here at the association's first annual meeting were: first vice president, True Taylor, Bethesda General Hospital and Bethesda-Dilworth Home, St. Louis; second vice president, Mary Jane O'Donnell, R.N., Becky Thatcher Home, Hannibal; executive secretary, Evelyn Stone, R.N., Stone Nursing Home, St. Louis; treasurer, Connie Gustafson, High Towers Nursing Home, Jennings; historian, Hans R. Pfeiffer, Englewood Nursing Home, Robertson; chaplain, Mary McClusky, R.N., Margaretta Nursing Home, St. Louis.

San Francisco Officers

SAN FRANCISCO. — Elmer O. Massmann, administrator of French Hospital here, has been reelected president of the San Francisco Hospital Conference. Other conference officers elected recently are: secretary, Sister Mary Philippa, administrator of St. Mary's Hospital, and treasurer, Mark Berke, administrator of Mount Zion Hospital.

New York Nurses Ask Increase in Salaries

NEW YORK. — Voluntary hospitals here were requested last month to increase starting salaries for general duty nurses from $3120 to $3500 a year.

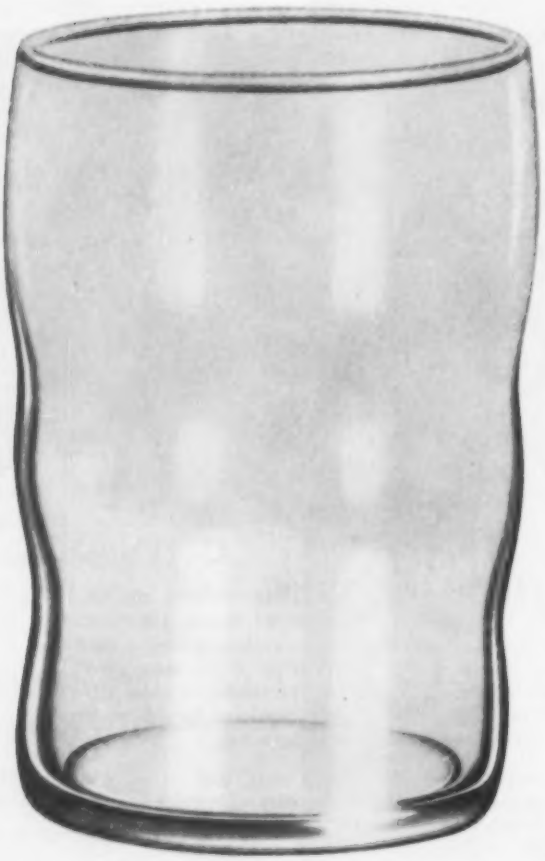
The request was made by the New York Counties Registered Nurses' Association's board of directors, which pointed out that municipal hospitals are now paying $3500 and some voluntary hospitals pay close to this amount.

The association, which covers approximately 3000 registered nurses in the New York area, also authorized private duty nurses to increase their pay from $14 to $16 for an eight hour day.

Speaking for the Greater New York Hospital Association, Louis Schenkweiler, chairman of the association's nursing committee, said the committee would consider the recommendation. However, he added, the hospital association is not a "bargaining agent" and could only make recommendations to its member hospitals for individual action.

Announcing...Libbey Heat-

Libbey Glass, Division of Owens-Illinois, is proud to establish the new standard of comparison—a yardstick for *continuous demonstration* of the ECONOMY of Libbey Heat-Treated Glassware.



WATER
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Treated DATED GLASSWARE

This is what the "**OPEN-SECRET**" of dated glasses has completely proved . . .

Libbey Heat-Treated Quality costs you far less than the "cheapest" glassware on the market!

For seven years, a code symbol on the bottom of Libbey Heat-Treated Glasses has made it possible to trace this revolutionary ware in almost every type of use.

Life of the glasses has naturally varied under different conditions. But the *comparative* story—the comparison with "inexpensive" glassware – has been repeated over and over.

Here, for example, is the up-to-date summary of the complete audits made in 1955 on a cross-section of restaurants of widely varying type and operating conditions.

	Average Servings per tumbler	Tumbler Cost per 1,000 servings
Restaurant "A" Washington, D. C.	739	8 and 4/5 cents
Restaurant "B" Philadelphia	1143	5 and 7/10 cents
Restaurant "C" Boston	3700	1 and 4/5 cents
Restaurant "D" Chicago	1340	4 and 3/10 cents
Restaurant "E" Toledo	1355	5 and 1/5 cents
Restaurant "F" Detroit	2025	4 and 2/5 cents
Restaurant "G" Atlanta	1254	6 and 1/10 cents

Result of this seven-year experience and examination of actual inventories is that Libbey Heat-Treated ware has literally proved itself better qualified to speak for itself than through any verbal claims.

You can check your glasses yourself. Just look at the heat-treated mark at the bottom of your tumbler. Numerals indicate date of manufacture – numeral at left shows year and numeral at right shows quarter. Add up the number of servings and you'll see how unbelievably economical Libbey Heat-Treated Glasses are.

Your Libbey Supply dealer has complete details. See him or write Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.

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Texas Purchasing Agents Organize; Develop Code

DALLAS, TEX. — Hospital purchasing agents in Texas have formed their own official association. At a recent meeting of the organizational committee, a constitution and by-laws were drawn up.

The preamble to the constitution includes an ethical code which reads:

"It has been said that hospitals started off as a refuge, a haven or a place where poor people went to die. Let us be thankful for the advance in science and medicine that today a hospital is not just a place for poor people, but rather for poor and rich alike, and not a place to go to die but rather a place in which life may be saved or prolonged, a place where people can regain their health and again find their place in society.

"We, as purchasing agents, need to set our goal upward to keep pace with the advancement in science and medicine in order to give the patient entrusted to the care of our hospital the best and latest available in equipment, supplies and technics for faster improvement and healing, because our job is dependent on the manner in which our hospital administers to the patient."

In order to do this job, the preamble pointed out, members must adhere to the following code of ethics:

1. We must always consider the interest of our hospital, and definitely believe in its established policies.
2. We must always be receptive to counsel from our associates and be guided by their counsel.
3. We must buy without prejudice, seeking always to obtain the maximum ultimate value for each dollar expended.
4. We must strive consistently for knowledge of materials and processes of manufacture.
5. We must subscribe to and work for honesty and truth in buying, and denounce all forms and manifestations of common bribery.
6. We must accord a prompt and courteous reception, so far as business will permit, to all who call on legitimate business.
7. We must respect our obligations and also require that those who call on us respect our policies and methods of doing business.
8. We should always avoid any sharp practices.
9. We should always try to create good public relations with all.

Catholic Association Plans May Meeting in Milwaukee

MILWAUKEE. — "Education, Research and Patient Care" will be the theme of the 41st annual convention of the Catholic Hospital Association to be held here May 21 to 24.

Meeting in preconvention session or simultaneously with the Catholic Hospital Association will be the conference of Catholic schools of nursing, the purchasing institute, the institute for hospital dietitians, conference on medical technology, the institute for hospital pharmacists, the medical record library institute, the bishops' representatives, the chaplains' conference, the institute for x-ray technicians, and a special two-day program for hospital auxiliaries.

Polio Foundation Aids Nurse Recruitment Program

NEW YORK. — The National Foundation for Infantile Paralysis has made a grant of $46,247 to the 1956 program of the Committee on Careers,

National League for Nursing. The grant, which was announced jointly by Basil O'Connor, president of the foundation, and John H. Hayes, chairman of the committee, marks the seventh year of N.F.I.P. support to the national nurse recruitment program.

The committee reports that, although the largest nursing force in history is active today, schools of professional nursing are seeking 50,000 new students. "More nurses will help assure adequate care for polio patients," said Mr. O'Connor.

Washington Nurse Survey Shows Majority in Hospitals

SEATTLE. — Two out of every three active nurses in the state of Washington are employed in hospitals and other institutions. A survey recently completed by the state department of licenses in cooperation with the Washington State Nurses' Association and American Nurses' Association also revealed that out of a total of 16,888 nurses registered in the state, only 7826 were practicing there.

The report showed that while the total number of registered professional nurses in the state had increased 15 per cent between 1951 and 1955, in the same period the number of nurses employed in hospitals and institutions increased 40 per cent.

Sixty-four per cent of hospital and institution nurses are married, and approximately the same number are between the ages of 20 and 44. Only 25 per cent of all active nurses are unmarried, the rest are married, divorced or widowed.

In addition to the 66.3 per cent employed in hospitals and institutions, 12.9 per cent are in office nursing; 8.8 per cent are in private duty nursing; 5.6 per cent in public health or school nursing; 2.4 per cent in schools of nursing, and 2.3 per cent in industrial nursing.

The largest group of nurses not practicing were between the ages of 30 and 39, with 1952 in this category. Ninety-five per cent of the inactive group maintaining current licenses are married, divorced or widowed.

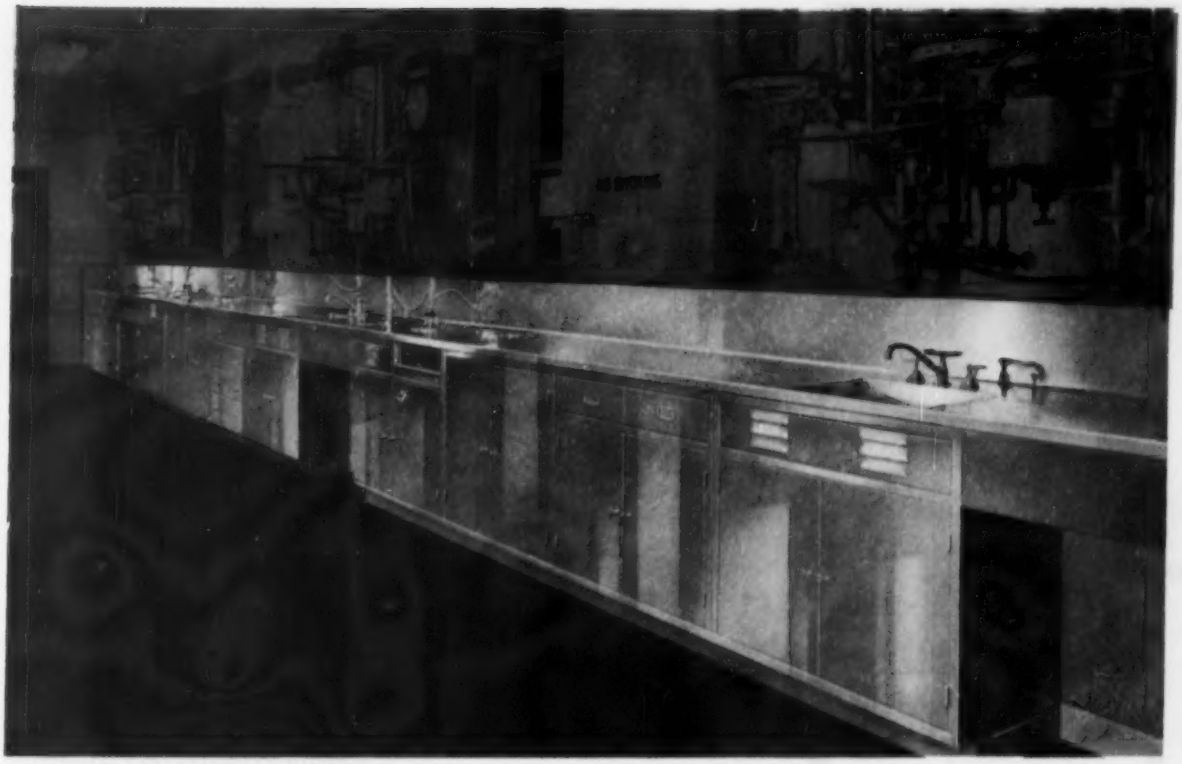
Of the 5192 nurses employed in hospitals and institutions, 3420, or 66 per cent, were general duty or staff nurses; 943, or 18 per cent, were head nurses or assistants; 593, or 11 per cent, were supervisors or assistants; 188, or 3 per cent, were administrators or assistants; 45, or 1 per cent, were instructors, and three were consultants.

Detailed studies of registered professional nurses have thus far been made only in Washington and Colorado. The results of studies in these states will be used as a basis for planning a national nurse inventory.

Oklahoma Association Elects New Officers

TULSA, OKLA. — Dave K. Huffman, administrator of Muskogee General Hospital, Muskogee, was installed as president of the Oklahoma Hospital Association at its 36th annual meeting here. Jack Shrode, administrator of Wesley Hospital, Oklahoma City, was chosen president-elect.

Other officers elected at the convention are: vice president, Robert E. Trimble, administrator, Parkview Hospital, El Reno; secretary, R. L. Loy, business manager, Mercy Hospital, Oklahoma City, and treasurer, Kenneth Wallace, assistant administrator, St. John's Hospital, Tulsa. Mr. Wallace was also named delegate to the American Hospital Association.



Charity Hospital, solution preparation room, planned and equipped by American Sterilizer Company. Stainless steel equipment manufactured by S. Blickman, Inc.

the spotless solution:

CRUCIBLE stainless steel

Many hospitals, like the 3,000-bed Charity Hospital in New Orleans, find big savings in operating their own solution departments. And to insure the spotless, sanitary conditions necessary, they rely on that old friend of the hospital, *stainless* steel.

In counters, sinks, automatic flask washers, rinsers, cabinets, sterilizers – highly polished stainless steel keeps things sparkling clean. The convenience of stainless *lasts*, too. Its tough, smooth surface defies wear. And since stainless is *stainless* all the way through, there's no surface plating to chip or peel away.

So when you're buying new equipment for the solution department – or the operating room, kitchen, laundry – or anywhere in the hospital – make sure it's made of Crucible *prescription-made stainless* steel. Nothing else gives a bigger bonus of long service, cleanliness and convenience. *Crucible Steel Company of America, Henry W. Oliver Building, Pittsburgh 30, Pa.*

CRUCIBLE first name in special purpose steels

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Home Care Program for Chronically Ill Launched by San Francisco Hospitals

SAN FRANCISCO.—A community-wide hospital-home care program has been undertaken here under the joint sponsorship of the federal Office of Vocational Rehabilitation, the Benjamin Rosenthal Foundation of New York, and the San Francisco Foundation, it was announced last month.

The plan has been endorsed by the San Francisco Hospital Conference and the San Francisco County Medical Society, it was reported.

The program seeks to provide home care for chronically ill patients by hospital-organized teams of physicians, nurses, social workers, and vocational rehabilitation workers, it was explained.

Approximately 30 selected patients will be cared for in the initial or experimental phases of the plan, at an estimated cost of $1500 a year per patient.

Mark Berke, director of Mount Zion Hospital here, estimated the cost of the home care program would be approximately 25 per cent of the cost of similar care in the hospital.

"Only patients who will be better off in their own homes, both psychologically and medically, than in hospitals, will be chosen," the announcement said. "The care of each patient will continue under the supervision of the hospital from which he is admitted to the home care program."

Eighteen San Francisco hospitals are cooperating in the program, with administrative headquarters at Mount Zion, it was explained. The San Francisco plan was reported to be the first citywide, multi-hospital-home care program in the country. Previous programs, including the one at Mount Zion, have been based at a single hospital.

"The team is to visit each patient once a week," the announcement said. "The team as a whole, with the aid of medical specialists and psychiatrists, will evaluate a patient's condition every two or three weeks. It may be found necessary for a therapist to visit the home two or three times a week, instead of one.

"If hospitalization is required the patient will be sent back to the hospital from which he entered the plan."

The program is planned to create a happier situation for the patients, Mr. Berke said.

"We are not taking patients away

the economy *and* convenience *of*
just one vial, just one injection, for combined
penicillin-dihydrostreptomycin therapy

The antibiotic combination favored by surgeons

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from hospital beds so much as adding another dimension to hospital care, in which we bring the hospital right to the patient's bedside at his home."

Dr. Edgar Munter, chairman of the San Francisco County Medical Society's committee on chronic illness, will be medical director of the program. Patients selected will be primarily those with such chronic conditions as heart disease, asthma, arthritis, and cancer, Dr. Munter said.

Endows Low-Cost Care for Middle Income Group

PITTSBURGH. — The will of an elderly widow has provided for a unique addition to a hospital here. Purpose of the bequest: to underwrite hospitalization costs for those of middle income. An estate estimated at $2 million has been willed to the Shadyside Hospital to build "a cottage or building with 12 or 16 rooms at a cost not to exceed $80,000."

No patient, said the testator, shall be charged more than $15 a week, based on the value of the dollar in 1942, when she drew the will. Money beyond the $80,000 is to be used for the operation of the structure.

Mrs. Ruth Bailey McMechen, who died in July at the age of 86, had become almost a permanent resident of the hospital. Her will stated:

"I have realized that people of wealth can purchase good care in our hospitals, and those in less favorable circumstances receive excellent care on account of the charity work performed in hospitals. But . . . the expenses of hospitalization fall heavily on the people of moderate means, and I want this memorial . . . to be used for their benefit."

Oklahoma Baptists Plan $15 Million Medical Center

OKLAHOMA CITY, OKLA. — Plans for a huge $15 million medical center to be built here have been announced by the Baptist General Convention of Oklahoma. Bids for construction of the first wing of a 500 bed hospital, the central unit of the project, are expected to be let in the next four months.

The center, to cover a 60 acre area, will eventually include nurses' homes, a home for the elderly, staff housing, a technical and professional area, an atomic medical laboratory, and a Baptist church.

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Dallas Hospitals Veto Plan for Joint Fund Campaign

DALLAS, TEX. — Hospitals here have turned down the idea of a joint campaign to raise $12,273,000 for 620 additional beds in favor of individual building campaigns.

The joint campaign was a recommendation of James A. Hamilton of Minneapolis, head of a firm of experts which spent eight months studying hospital needs in Dallas.

After studying the report, a committee of Dallas hospital administrators, in consultation with board members from four hospitals, decided that such a campaign could not succeed here at this time.

The group said it was in hearty agreement with the expansion objectives of the proposed campaign, but recommended that the money be raised in individual campaigns.

Priority has been given to the $3,500,000 campaign for Methodist Hospital, whose needs were reported to be most critical. The campaign will open May 15.

The fund drive proposed by Mr. Hamilton would have added the 620 beds to five hospitals here. The beds would have been added in the following priority:

1. Methodist: 218 additional beds plus 42 new beds to replace beds in halls and other unsuitable locations; total, 260 beds; approximate cost, $4,780,000.
2. Baylor: 130 beds (90 general and 40 nervous-mental) at a cost of $2,890,000.
3. St. Paul's: 60 new beds, plus 56 replacements; total, 116 beds at a cost of $2,430,000.
4. Children's Medical Center: 24 new beds plus 48 replacements; total, 72 beds at a cost of $1,490,000.
5. Gaston Hospital: 42 new beds; cost, $683,000.

Storz Honored at Clarkson Hospital Dedication

OMAHA, NEB. — At a dedicatory dinner for the $5 million Bishop Clarkson Memorial Hospital here, civic leaders honored Robert H. Storz, who has been described as the driving force behind the new hospital. Mr. Storz is vice president of the Clarkson board of trustees and chairman of the building committee.

A portrait of Mr. Storz was unveiled and hung in the lobby of the hospital. A tribute accompanying the portrait noted that he had "given most generously of his time, talents and resources to the creation of a greater Clarkson Hospital."

Cook County Hospital Opens New X-Ray Department

CHICAGO. — An x-ray department occupying 13 rooms and a total of 24,500 square feet was opened at Cook County Hospital here recently.

Hospital officials said it was believed to be the largest and most complete diagnostic x-ray department in the world.

The new equipment features automatic electronic and electrically operated facilities approaching automation in x-ray services, the hospital said.

These facilities include a universal planigraph enabling physicians to concentrate on a particular organ, bone, joint or area by blocking out surrounding tissue and bringing the area under examination into sharp focus, and an electronic timer permitting measurement of the flow of blood in the patient's heart and brain, through successive exposures electronically timed.

COMING EVENTS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Meeting, Palmer House, Chicago, Sept. 15-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS INSTITUTES: Minnesota, University of Minnesota, Minneapolis, Feb. 20-24; 24th Chicago, University of Chicago, Sept. 6-14; 7th Chicago Advanced, University of Chicago, Sept. 10-14; Educational Conferences: Belmont Plaza Hotel, New York, Feb. 13-17; Congress Hotel, Chicago, Mar. 12-16.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Palmer House, Chicago, Sept. 17-20; Midyear Conference for Presidents and Secretaries of State Hospital Associations, Palmer House, Chicago, Feb. 6, 7.

AMERICAN HOSPITAL ASSOCIATION INSTITUTES: Evening and Night Nursing Service, Chicago, Jan. 30-Feb. 2; Hospital Personnel, Kansas City, Mo., Feb. 13-17; Hospital Planning, Washington, D.C., Feb. 13-17; Financial Management and Accounting Control, Chicago, Feb. 13-17; Hospital Laundry Management, Boston, Feb. 15-17; Supervisory Training Workshop, Boston, Feb. 27-Mar. 2; Nursing Service Administration, Portland, Ore., Feb. 27-Mar. 2; Medical Record Library Personnel, Salt Lake City, Utah, Mar. 12-16; Dietary Department Administration, Chapel Hill, N.C., Mar. 12-16; Hospital Laundry Management, Atlanta, Ga., Mar. 20-22; Central Service Administration, Buffalo, N.Y., Mar. 26-29; Hospital Engineering, Atlanta, Ga., April 2-6; Operating Room Administration, Nashville, Tenn., April 9-12; Medical Social Workers, Chicago, April 9-13; Hospital Insurance, Kansas City, Mo., April 23, 24; Occupational Therapy, St. Louis, April 23-27; Hospital Auxiliary Leadership, Seattle, April 24, 25; Hospital Law, Atlantic City, N.J., May 14, 15; Insurance for Hospitals, San Francisco, May 31-June 1.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, St. Louis, Feb. 8-10.

ASSOCIATION OF WESTERN HOSPITALS, Olympic Hotel, Seattle, April 23-26.

BLUE CROSS PLANS, Annual Conference, Hollywood Beach Hotel, Hollywood Beach, Fla., April 8-12.

CALIFORNIA HOSPITAL ASSOCIATION, San Jose, Oct. 24-26.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 12, 13.

CATHOLIC HOSPITAL ASSOCIATION, Public Auditorium, Milwaukee, May 21-24.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Claridge, Atlantic City, N.J., May 16-18.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, N.J., May 16-18.

INTERNATIONAL CONGRESS ON MEDICAL RECORDS, Shoreham Hotel, Washington, D.C., Oct. 1-5.

IOWA HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, April 26.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 15, 16.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Phoenix, Lexington, April 3-5.

LOUISIANA HOSPITAL ASSOCIATION, Jung Hotel, New Orleans, May 24, 25.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Oct. 31-Nov. 2.

MASSACHUSETTS HOSPITAL ASSOCIATION, Statler Hotel, Boston, May 10.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 17, 18.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo., April 25-27.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Hotel Jefferson, St. Louis, Feb. 8, 9.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Edgewater Beach Hotel, Chicago, May 7-11.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, March 26-28.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 16.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, March 12-14.

NORTH DAKOTA HOSPITAL ASSOCIATION, Grand Pacific Hotel, Bismarck, April 24, 25.

OHIO HOSPITAL ASSOCIATION, Deshler-Hilton Hotel, Columbus, April 9-12.

SOUTHEASTERN HOSPITAL CONFERENCE, Miami Beach, Fla., April 18-20.

TENNESSEE HOSPITAL ASSOCIATION, Hotel Claridge, Memphis, June 21-23.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, April 3-5.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 30-May 3.

UPPER MIDWEST HOSPITAL CONFERENCE, Nicollet Hotel, Minneapolis, May 23-25.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 16, 17.

WISCONSIN HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, March 15.

WORLD CONFEDERATION FOR PHYSICAL THERAPY, Second Congress, Statler Hotel, New York, June 17-23.

St. Louis Council Reelects Officers

ST. LOUIS. — Sister Mary Brendan, R.S.M., administrator of St. John's Hospital here, was reelected president of the Greater St. Louis Hospital Council at its annual meeting January 10.

Also reelected were first vice president, Dr. W. E. Hennerich, hospital commissioner of St. Louis; second vice president, Harry E. Panhorst, associate director of the Barnes Hospital group; secretary, Addie Mullins, administrator of Christian Hospital, and treasurer, Cornelia S. Knowles, administrator, McMillan Hospital. Dr. David Littauer, executive director of Jewish Hospital, was reelected for a three-year term to the board of directors. Other directors are Sister Margaret Alacoque, C.S.J., administrator of St. Joseph's Hospital, Kirkwood, and Dr. A. J. Signorelli, administrator of Faith Hospital.

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Renton Hospital Staff and Board to Arbitrate

(*Continued From Page* 81)

basis for six-year terms, should determine the qualification of doctors to serve on the medical staff.

"The settlement we have reached assures at least that there will be medical appraisal of the professional ability of all staff physicians."

The statements of both spokesmen point up as a basis for the controversy the wording of Washington's unique law which permits establishment of a hospital district, similar to a school district, as a municipal corporation with power to levy taxes for purposes of buying, building or operating hospitals.

The controversial wording in the law reads that "medical management" of the hospital "shall be subject to the approval of the medical staff."

The words "medical management" were nowhere defined.

Attorneys involved with the first functionings of the hospital interpreted "medical management" broadly. Some older members of the medical staff felt that the power of the commissioners was limited to collection of the tax levies, budgeting and other purely administrative affairs.

The hospital district law was enacted just after World War II to meet the specific needs of the community of Renton, an industrial and farming center on the southern outskirts of Seattle.

The Federal Works Agency had built the 100 bed, 35 bassinet hospital in 1945 because of the spurting population that followed the Boeing Airplane Company to Renton.

For the first two years, the hospital was operated by a nonprofit corporation. The medical staff, drawn primarily from general practitioners of the city and surrounding farm communities, had broad responsibilities in its operation.

The Renton Public Hospital District was formed in December 1947. Until 1953, the by-laws of the nonprofit hospital covering staff appointments, rules and regulations were maintained in force.

These by-laws had been drawn up by the medical staff and were accepted by the commissioners when the public hospital was established.

Procedure was that new staff members be appointed by the board on recommendation of and after investigation by the staff. All appointments were for one year. The staff could recommend against reappointment of any staff doctor, or the board could take the initiative in refusing a reappointment and take final action only after asking staff recommendations.

The staff elected its own officers and executive committee.

Then the commissioners in 1953 adopted a new set of by-laws, an action known as Resolution No. 19.

This provided that the board would appoint the chief of staff and two other officers of the staff, and the staff would elect two other members of the executive committee.

Resolution No. 19 provoked a flare-up of criticism by the staff members, who charged that the board was interfering with the physicians' rights of self-government.

Then the commissioners denied hospital privileges for 1955 to Dr. Liberino Patricelli, whose reappointment had been opposed by some members of the staff.

Dr. Patricelli promptly filed suit for an injunction against the commissioners and $50,000 in damages from the hospital district and the commissioners.

(*Continued On Page* 161)

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(Continued From Page 160)
His complaint alleged "arbitrary and capricious" action of the commissioners had deprived him of "the means of caring for his patients" and had damaged his business and professional reputation and his credit.

The flare-up erupted into a full-size volcano with this step.

Twenty-five members of the 32 member staff, including Dr. Jack R. Morrison, then chief of staff, filed a complaint in intervention in Dr. Patricelli's suit, hoping for a court airing of the "medical management" controversy. Superior Court Judge Donald A. McDonald quashed the complaint in intervention, however. So the 25 doctors filed their own suit.

They sought court nullification of Resolution 19 and an injunction against the commissioners to prevent their interference in the determination of membership and officers of the medical staff.

Seven members of the medical staff did not join in this litigation.

The Patricelli suit was settled out of court Sept. 12, 1955. Dr. Patricelli was reinstated to the hospital medical staff, but with the provision he can perform no pelvic or major surgery in the hospital for an 18 month period without prior consultation with and approval of the surgery by another physician from a list of doctors drawn up by the staff executive committee and the board. The medical society will intervene on selection of doctors for the list, if there is disagreement on those listed.

Legal counsel for the medical society had conferred with the doctors on the medical staff in reaching the Patricelli settlement. So it was natural that the medical society be established as a buffer agency in the event of further disputes between staff and commissioners.

Final authority remains with the commissioners. But when there is a disagreement on staff appointments, reappointments or removal of members, or on questions of membership on the staff executive committee or doctors' privileges in surgery, the medical society will be asked for its opinion and recommendations.

In the event of an order removing a doctor, he is granted a hearing assuring him that he will not be deprived of privileges without "due process," as the staff charged had been possible previously.

Members of the staff executive committee and its officers will be elected by the staff doctors themselves, subject to commissioners' approval. The county medical society again will act as an intervening arbiter in the event of a disagreement, but the commissioners will not be bound by the society's recommendation.

There are indications that all may work out better than either side now foresees.

The administrator of a near-by private hospital who is familiar with the situation at Renton said he believes the agreement may bring "greater acceptance of responsibility by the staff and more cooperation from the board."

A Renton citizen who is close to all the principals said: "This machinery has given the doctors something to work with, and relieved the strain on them.

"The doctors are rugged individualists who don't like to be regulated. The commissioners don't think they should have the responsibility of operating the hospital without a determination of its policies.

"There is every chance that now the heat has been expended there will be increasing cooperation all around."

Chronic Illness Commission Ends June 16; Work to Be Carried on by Founders

BALTIMORE. — The Commission on Chronic Illness will end its official existence on June 16. At its sixth annual meeting, the commission voted to terminate its activities concurrently with expiration of its articles of incorporation. It is hoped that projects now under way can be completed so that the national office here can close as soon after mid-June as possible, a commission statement said.

"Now that the commission has laid the foundation and pointed the way to a nationwide attack on chronic illness, continued progress is dependent on the leadership of other groups. The commission's founding organizations are already laying their plans," the statement said.

Commenting on the termination of the commission, Dr. Edwin L. Crosby, director of the American Hospital Association, said, "The American Hospital Association will devote in the future a substantially greater share of its resources to assist hospitals to meet their obligations in this area."

Beginning with the February issue, the *Chronic Illness News Letter* will be published by the Council on Medical Service of the American Medical Association. Commission members Dr. Henry Mulholland, Lucille Smith and Dr. Dean W. Roberts, along with Dr. Edward L. Bortz, have been appointed editorial committee for the publication.

No change in editorial policy is contemplated, and the news letter's present mailing list will be maintained.

The commission was founded and incorporated as a temporary organization and has received financial support for its activities on this basis. Originally it was hoped that the commission could complete its work in from three to five years; however, this was found to be impossible. It will have been in existence seven years since its incorporation in 1949.

The commission believes its original assignments have been carried out and that the next steps in forwarding a national program for chronic disease can best be taken by the founding organizations and other permanent agencies concerned with chronic illness, said an official statement.

The founding organizations are: American Hospital Association, American Medical Association, American Public Health Association, and Amer-

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ican Public Welfare Association. A joint committee of these organizations invited commission members to organize as a group for the purpose of studying the problems created by the increase of chronic illness in this country.

Commission members have been chosen primarily as representative citizens interested in the problems of chronic illness, rather than as individuals representing particular organizations or fields of knowledge. Among the 30 current members are men and women from industry, agriculture, education, welfare, religion, journalism, law, labor, public health, medicine, hospitals and government. In addition, the commission has had the services of 41 technical advisers.

Accreditation Commission Issues Standards for Medical Records Procedure

CHICAGO.—Medical records are evaluated according to whether or not they contain sufficient information to justify the diagnosis and warrant the treatment and result, the Joint Commission on Accreditation of Hospitals said here last month in a bulletin on medical records.

The bulletin set forth the standards of medical records procedure on which the records departments of hospitals are judged for accreditation.

"Medical records are an important tool in the practice of medicine," the bulletin stated, introducing the standards. "They serve as a basis for planning patient care, they provide a means of communication between the physician and other professional groups contributing to the patient's care, they furnish documentary evidence of the course of the patient's illness and treatment, and they serve as a basis for review, study and evaluation of the medical care rendered to the patient.

"For these reasons, the Joint Commission on Accreditation of Hospitals considers the quality of medical records an important indication of the quality of patient care given in a hospital."

The standards set forth in the bulletin cover the content, signature, form, filing, maintenance, preservation and ownership of medical records, with special provisions made for covering obstetrical records, readmissions and nurses' notes.

Under content, the commission requires that a medical record shall contain adequate identification data, provisional diagnosis, chief complaint, present illness, history and physical examination, consultation record, clinical laboratory reports, x-ray reports, tissue report, treatment record, progress notes, final diagnosis, summary, and report of autopsy findings when autopsy is performed.

Considering the matter of signatures, the commission stated:

"1. In hospitals without house officers the attending physician should separately sign the history, physical examination, operative report, progress notes, drug and other orders, and the summary. Standing orders should be reproduced on the record and signed by the physician.

"2. In hospitals with house officers, the attending physician should countersign at least the history, physical examination and summary written by the house officer. Aside from the fact that this is a legal requirement in many states, it is a protection to the individual physician. It is not considered necessary to countersign progress notes or drug and treatment orders written by house officers. In all instances a

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physician should sign the clinical entries which he himself makes.

"3. A single signature of the physician on the face sheet of the medical record does not suffice to authenticate the entire content of the record.

"4. The use of rubber stamp signatures is acceptable under the following strict conditions: (a) The physician whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it; (b) the physician places in the administrative offices of the hospital a signed statement to the effect that he is the only one who has the stamp and is the only one who will use it.

"5. Initials in place of a full signature are acceptable provided that the initials can be recognized as having been placed there by a particular physician who can be identified by those initials."

The commission has no specific requirements concerning nurses' notes, the bulletin indicated. "It is the responsibility of the local medical and nursing staffs to develop policies concerning the type and extent of nurses' notes to be kept," it said.

The use of "short form" records is acceptable in minor cases requiring less than 48 hours of hospital care, it was indicated.

"Short forms may be appropriate for such conditions as tonsillectomies, cystoscopies, lacerations, plaster casts, removal of superficial growths, and accident cases held for observation," the bulletin said. "The short form should at least include identification data, a description of the patient's condition, pertinent physical findings, an account of the treatment given, and any other data necessary to justify the diagnosis and treatment. The record should be signed by the physician."

Among the other provisions set forth in the bulletin were the following sections:

"1. Filing and Maintenance of Medical Records: (a) Current records should be completed insofar as possible within 24-48 hours; (b) after discharge, records should be completed insofar as possible within 10-15 days; (c) a system of identification and filing to ensure the rapid location of a patient's medical record should be maintained. The unit number system is suggested; however, a serial number system or modification of this is acceptable; (d) records should be indexed according to disease, operation and physician; (e) if medical records are coded, it is suggested that the Standard Nomenclature be used.

"2. Preservation of Medical Records: The Joint Commission on Accreditation of Hospitals has no standards governing the preservation of medical records. The length of time a medical record is preserved is a matter which should be determined by the local hospital and local laws. Method of preservation by microfilming or other means of storage is a decision for the individual hospital to make.

"3. Ownership: The medical record is the property of the hospital and is maintained for the benefit of the patient, the physician and the hospital. It is the responsibility of the hospital to safeguard the information on the record against loss, tampering or use by unauthorized persons."

Lay Board Can't Assume Medical Responsibilities, Cleveland Attorney Says

BOSTON. — The quality of medical care will be diminished if lay hospital administrators assume the responsibilities of physicians, John Lansdale Jr. of Cleveland, attorney for the American Society of Anesthesiologists, Inc., said at a meeting of the society here recently.

The protection of hospital patients must remain with the medical profession and not be handed over to lay boards of trustees and administrators, Mr. Lansdale asserted.

More than 2000 delegates from all sections of the United States attended the society's annual convention.

In most hospitals, the board of trustees has the legal power to appoint the staff and set professional standards, Mr. Lansdale explained. This is an effective mechanism to maintain standards of medical care, he acknowledged.

"But to say that the board of trustees of the hospital is legally and morally responsible for the quality of medical care is not only an overstatement of fact but suggests the assumption of a responsibility which the board is not equipped in any degree to discharge," he asserted.

The physician, not the board or administrator, is legally and morally responsible for the care of hospital patients, and the medical profession should establish and enforce standards of conduct for doctors, Mr. Lansdale concluded.


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SURGEONS NEEDLES

"Better Merchandising of Health" Urged by Rusk at Centennial Celebration

BOSTON. — A department store kind of organization has been recommended for the hospital of the future to "merchandise the product" of good health. The reorganization should begin in operating and recovery rooms, with a special floor for the critically ill, asserted Dr. Howard A. Rusk in a recent address at the centennial celebration of Massachusetts Memorial Hospitals.

On any given day, he pointed out, only 10 per cent of a hospital's patients need constant professional attention. From a section for the critically ill, patients would progress to a section for routine treatment where less serious illness could be handled. As the patient improves, he would be moved to convalescent and rehabilitation facilities, Dr. Rusk recommended.

Dr. Rusk is professor and chairman of the department of physical medicine and rehabilitation at the New York University-Bellevue Medical Center and associate editor of the *New York Times*.

He also suggested a hotel-like wing for diagnostic patients, who could eat in a common dining room whenever not specifically required to remain in bed during tests.

Dr. Rusk advocated a "homestead type" of institution for the chronically ill and disabled, which would provide good food, cleanliness and the "chance for a little fun."

The Memorial Hospitals Centennial Gold Medal was given to Dr. Rusk for his "distinguished contributions to the health of the American people."

A day-long symposium on "Health for the American People" was also a part of the centennial observance. Panel discussions emphasized the growing importance of preventive medicine.

"There is a good possibility that in a five-year period the national health level could be improved by 10 per cent if preventive health care were made available to all families," said Dr. Chester S. Keefer, director of Boston University School of Medicine and physician-in-chief of Massachusetts Memorial Hospitals.

Dr. Keefer noted that the general practitioner will be increasingly important in preventive medicine, serving as the family guide to health, calling upon specialists when needed for diagnosis and treatment. The general practitioner must be an integral part of the institutional hospital setup, said Dr. George Crile Jr., director of Cleveland Clinic. Dr. Edwin F. Daily, vice president of the Health Insurance plan of Greater New York, called for the use of medical group centers for group practice.

Broad health insurance coverage was also noted as essential. "A comprehensive package of constructive medicine designed to keep people well, enhance health, prevent disease, and discover and treat illness promptly is necessary," said Dr. Keefer. A preliminary statement by one panel pointed out that the major portion of illness falls on a relatively small group of the population, making the insurance principle invalid unless steps can be taken to control avoidable or excess risk and prevent illness.

In discussing community action for health, Dr. Leonard A. Scheele, surgeon general, U.S. Public Health Service, said that wider representation and cooperation of community groups were vital in effective planning.

ABOUT PEOPLE

(*Continued From Page 86*)

James C. Heidenreich has been named assistant administrator at Iowa Methodist Hospital, Des Moines. Prior to his appointment Mr. Heidenreich was assistant administrator at Santa Barbara Cottage Hospital, Santa Barbara, Calif., where he also served his administrative residency. He is a graduate of Northwestern University's course in hospital administration.

Dr. Eric P. Stone, director of professional services at the Veterans Administration Hospital in Boston, has been appointed manager of the V.A. hospital at Manchester, N.H.

Glenn V. Bailey has been appointed assistant director of the Niagara Falls Memorial Hospital, Niagara Falls, N.Y. Mr. Bailey was formerly assistant to the director of Harper Hospital, Detroit. He is a graduate of the Columbia University course in hospital administration.

Dr. James D. Murphy, chief of surgical service at the Veterans Administration Hospital in Oteen, N.C., has been appointed manager of the V.A. hospital at Baltimore. He succeeds **Dr. Theodore R. Dayton,** who will retire.

W. C. McBride is the new administrator of Hurst Eye, Ear, Nose and Throat Hospital in Longview, Tex.

Kenneth James Shouldice has been named administrative assistant at Milwaukee County Hospital, Milwaukee. Mr. Shouldice is a graduate of Northwestern University's course in hospital administration, and served his residency at Milwaukee County Institutions and Departments, Milwaukee. He succeeds **Harry D. Altman,** who has accepted the position of assistant administrator at the Community Hospital, San Mateo, Calif.

Lewis E. Bates has been appointed administrator of Crisp County Hospital, Cordele, Ga., succeeding **Elinor Waring.** Mr. Bates is a graduate of the University of Georgia school of hospital administration. He was formerly a field representative, division of hospital services, Georgia Department of Public Health, and administrator of Bamberg County Memorial Hospital, Bamberg, S.C.

Donald L. Ford, former administrative assistant at the Children's Hospital of Philadelphia, is now assistant director there. He succeeds **Dwayne L. Hall,** who has been appointed administrator of Ryburn Memorial Hospital, Ottawa, Ill.

Kyser Cox

Kyser Cox and **Edward G. Hertfelder Jr.** have been appointed administrative assistants at University Hospital and Hillman Clinic, University of Alabama Medical Center, Birmingham. Mr. Cox is administrative assistant for the credit and collections department. He was formerly administrator of the Bullock County Hospital, Union Springs, Ala. Previously he had been associated with Charity Hospital, New Orleans, and had been assistant administrator of the City-County Hospital, LaGrange, Ga. Mr. Hertfelder is assistant administrator and night administrator. He recently completed his administrative residency at Jackson Memorial Hospital, Miami, Fla. He is a graduate of the University of Toronto's course in hospital administration.

J. E. Janzen is the new administrator of Naeve Hospital, Albert Lea, Minn. Mr. Janzen was formerly administrator of the Chisholm Memorial Hospital, Chisholm, Minn. He succeeds **Norval W. Hodgson,** who is now administrator of the Masonic Home at Bloomington, Minn.

Sister Zephirin has been named administrator of St. John's Hospital, Port Townsend, Wash. Sister Zephirin has been administrator of St. Joseph's Hospital, Burbank, Calif., and has also been associated with Alaska hospitals of the Sisters of Charity of Providence. Formerly she was director of the Providence Hospital School of Nursing, Seattle. She succeeds **Sister M. Oliver.**

John F. Blend has been appointed administrator of Jackson-Madison County General Hospital, Jackson, Tenn. He succeeds **Ernest L. Bliss,** whose new appointment was announced last month in these columns.

Sally E. Knapp is the new assistant director at Grasslands Hospital, Valhalla, N.Y. Miss Knapp was formerly administrative assistant at Rhode Island Hospital, Providence, R.I., and previously was administrative resident at Syracuse Memorial Hospital, Syracuse, N.Y. She is a graduate of the Columbia University course in hospital administration and a nominee of the A.C.H.A.

Edward A. Thomson has been appointed administrator of the new Cameron Community Hospital, Cameron,

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Mo. Prior to his appointment, Mr. Thomson was business manager of St. Joseph Hospital, St. Joseph, Mo.

Dr. Joseph B. Bounds, manager of the Veterans Administration Hospital at Jefferson Barracks, Mo., has been appointed to the same position at the V.A. hospital in Roanoke, Va. Dr. Bounds was formerly associated with V.A. hospitals in Arkansas and Wisconsin. During World War II he served in the U. S. Navy Medical Corps, with the rank of commander. He succeeds **Dr. Charles W. Grady,** who retires this year.

Donald A. Starr has been appointed business manager of the Tucson Clinic, Tucson, Ariz. Previously, he held the position of assistant administrator at Scott and White Memorial Hospitals, Temple, Tex.

Frank J. De Scipio is the new assistant superintendent of Manhattan Eye, Ear and Throat Hospital, New York. Formerly, Mr. De Scipio was administrative assistant at Memorial Center for Cancer and Allied Diseases, New York. He is a graduate of the Columbia University course in hospital administration, and served his administrative residency at the U.S. Public Health Service Hospital, Staten Island, N.Y.

F. J. De Scipio

I. Marshall Whisnant Jr. has been named assistant director of Holston Valley Community Hospital, Kingsport, Tenn. Mr. Whisnant is a graduate of the School for Hospital Administrators, Charlotte Memorial Hospital, Charlotte, N.C.

Phil Carter, administrator of the Bataan Memorial Methodist Hospital, Albuquerque, N.M., has been appointed administrator of Methodist Hospital, Lubbock, Tex.

James Williams is the administrator of Tillman County Hospital, Frederick, Okla. Mr. Williams was formerly assistant manager and laboratory technician at McCurtain County Memorial Hospital, Idabel, Okla.

C. T. Madden of Phoenix, Ariz., has assumed the duties of administrator of the Coke County Memorial Hospital, Robert Lee, Tex.

Carden M. Astin has been appointed administrator of La Follette Community Hospital, now under construction in La Follette, Tenn.

Joe Taylor, assistant administrator of the Tennessee Department of Mental Health, has been named administrator of Memorial Hospital, Orangeburg, Tex.

Jacqueline Johnson has been named assistant to the administrator of Heights Hospital, Houston, Tex. For the last 14 years Mrs. Johnson has served as head accountant and purchasing agent for the hospital.

Department Heads

Harrison P. Attaway is the new director of supply services at Menorah Medical Center, Kansas City Mo., succeeding **Rose W. Koren.** Mr. Attaway was formerly vice president of the Gulf States Hospital Supply Company, Houston, Tex.

W. Park Woodrow has been appointed director of public relations at Jeanes Hospital, Philadelphia. Prior to his appointment, Mr. Woodrow was director of publicity and vocational counselor for men at Swarthmore College, Swarthmore, Pa.

Carl R. Baum, formerly assistant director of the Children's Hospital in Buffalo, N.Y., has been appointed controller of the Children's Hospital of

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Philadelphia. At the same time it was announced that **H. Percival Glendinning** had been named director of development at the hospital. Formerly, Mr. Glendinning was president of the board of Chestnut Hill Hospital, Philadelphia, and has also served as acting administrator of that institution.

Herman E. Schieke is the new administrative engineer at Johns Hopkins Hospital, Baltimore. Mr. Schieke retired from the U.S. Navy last June with the rank of captain, after 30 years of service. He had served as engineering officer of several different types of naval ships and also as instructor in the department of electrical engineering and physics at the Naval Academy. In 1951 he was appointed to the joint staff of the Joint Chiefs of Staff, specifically concerned with sea, land and air transportation.

Miscellaneous

Robert Sigmond

Robert Sigmond has been appointed executive director of the newly reorganized Hospital Council of Western Pennsylvania, Pittsburgh. Mr. Sigmond was formerly assistant to the executive vice president of Albert Einstein Medical Center, and previously had been associated with the Commission on Financing of Hospital Care, the Hospital Council of Philadelphia, and the Pennsylvania committee on hospital facilities, standards and organization.

Ronald A. Jydstrup has assumed the duties of executive director of the North Dakota Hospital Service Association. Prior to his new appointment, Mr. Jydstrup was accounting specialist and secretary of the committee on accounting and business practice of the American Hospital Association. He was also an instructor in hospital administration at the University of Minnesota for three years and an accounting consultant. **Donald W. Eagles,** former executive director of both the North Dakota Physicians' Service Association (Blue Shield) and the North Dakota Hospital Service Association (Blue Cross), is now director of the Blue Shield plan.

Edward J. Connors has been appointed instructor in hospital administration at the school of business administration, University of Michigan. Mr. Connors received his M.H.A. de-

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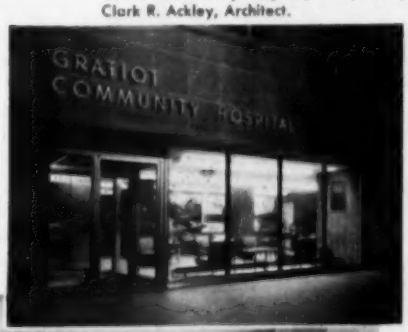
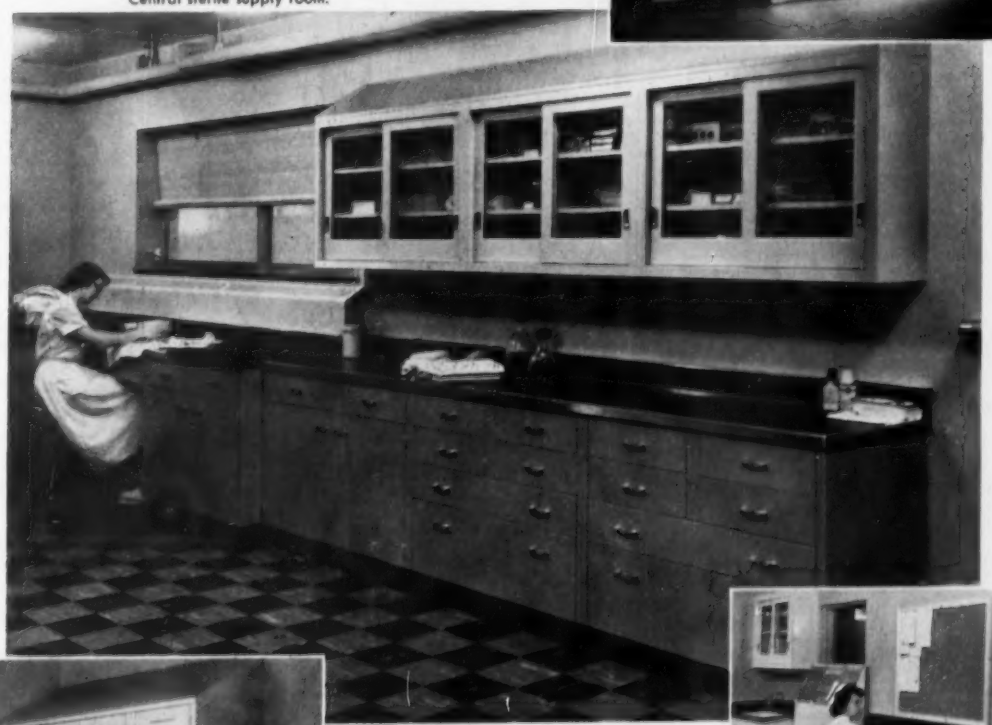
HOSPITAL CASEWORK

Gratiot Community Hospital, Alma, Mich.; Clark R. Ackley, Architect.



Central sterile supply room.



Nurses' station; Arthur B. Allaben, Administrator, shown at right.

Wardrobe in a patient's room.

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gree from the University of Minnesota. He completed his administrative residency at Rhode Island Hospital, Providence, R.I., later becoming administrative assistant there.

Ralph W. Nelson, hospital consultant, has been named executive secretary of the Oregon Association of Hospitals. He will also be adviser in hospital and professional affairs for the Oregon Blue Cross plan, Northwest Hospital Service. Mr. Nelson was administrator of Portland Sanitarium and Hospital from 1917 to 1955. He is a past president of the Oregon Hospital Association and the Portland Council of Hospitals.

C. J. Foley, a member of the headquarters staff of the American Hospital Association for the last nine years, resigned last month to become a consultant in public relations for hospitals and health organizations. Mr. Foley was public relations director of the association for six years, executive editor of the journal *Hospitals* for two years, and, for the past year, assistant to the director. Prior to joining the A.H.A. staff, he had been managing editor of *Hospital Management* and public relations director of Blue Cross plans in St. Louis and Wisconsin.

Deaths

Dr. Felix Adams, superintendent of Eastern State Hospital at Vinita, Okla., died December 3 at the age of 71. Dr. Adams was appointed to his position in 1912 and was the only superintendent the institution had had. He was active in Oklahoma's mental health program.

Lawrence C. Austin, formerly executive officer of Wichita Veterans Administration Hospital, Wichita, Kan., died in New York, December 12, at the age of 61. Mr. Austin had also served as administrator of Mount Sinai Hospital in Milwaukee and Menorah Hospital in Kansas City, Mo. During World War II, he served with the army medical corps.

P. Godfrey Savage, director of the Niagara Falls Memorial Hospital, Niagara Falls, N.Y., from 1922 to 1953, died December 6, in Clearwater, Fla. Mr. Savage was a former president of the New York State Hospital Association and a fellow of the American College of Hospital Administrators.

Dr. Crawford N. Baganz, manager of Veterans Administration Hospital at Lyons, N.J., died December 21 at the age of 50. Dr. Baganz had been associated as a psychiatrist with the Menninger Foundation, Topeka, Kan., and with the medical school of the University of Arkansas. He was secretary of the committee on certification of mental hospital administrators of the American Psychiatric Association.

THE BOOK SHELF

PLANNING NEW INSTITUTIONAL FACILITIES FOR LONG-TERM CARE. *By Edna E. Nicholson. New York: G. P. Putnam's Sons.* 1956. *Pp.* 398. $4.50.

This is a good book. It deals with a live topic in spite of its "chronic" subject — now, at last, "acute." The author belongs to a small band of devoted communal workers who were in the vanguard during the days of disinterest, darkness, discouragement and frustration. We now know, thanks to the intelligent persistence of this group, that prolonged illness has quantitative and qualitative significance which was unobserved or unappreciated in the days when "chronic" disease was equated with incurable disease.

This useful volume is the product of 10 years of intensive study, based on numerous consultations, association with hundreds of institutions and homes, and an active information service. It was carried out by the Central Service for the Chronically Ill of the Institute of Medicine of Chicago, under the direction of the author. Out of this experience many questions are now answered for the student of hospitalization. Some may feel, as I do, that a bibliography on the subject might have been appended with considerable profit to the reader, and resorted to in the text for comparative purposes, but such a book has its limitations in space. The objective here was to spread before a wider audience the facts gleaned by the Institute—information which appears to be substantial and stands by itself.

Five "forewords" precede the author's introduction, each of them by a representative personality who testifies to the worth of this timely book. The strength of its pages consists in the analysis of characteristics and needs of the patient suffering from prolonged illness, as seen from the local point of view after years of careful study. It is refreshing to read once

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more that the integration of "acute" and "chronic" is the method of choice.

Until the time comes when men will die peacefully in their sleep at a great old age, death and, in fact, all illness without exception will have to be dealt with as "acute" phenomena in the manner outlined in this book. —E. M. BLUESTONE, M.D.

MANUAL ON INSURANCE FOR HOSPITALS. *Published by the American Hospital Association, Chicago.* 1955.

This book is impressive in appearance, cleverly designed in loose-leaf form, and conveniently cross-indexed for reference purposes. Hospital administrators will find it helpful and instructive. Insurance agents and brokers who deal with hospitals, or who hope to do so, will find it invaluable, and I hope it will be available to these people at a proper cost.

From a professional point of view, I would say the book discusses in a manner understandable to the layman the basic terms and conditions of the types of policies with which hospitals usually have to deal. Chapter 1, entitled "The Insurance Industry," Chapter 6, entitled "Principles of Insurance Buying," Chapter 7, entitled "Insurance Records and Appraisals," Chapter 8, entitled "Claims," and Chapter 9, entitled "Sample Hospital Insurance Program," will give the average businessman a good basic knowledge of these subjects with which the hospital administrator is concerned.

It is fair, I believe, to state that this manual, helpful as it is, will hardly do more for the hospital administrator and board of trustees than to put their knowledge of these highly technical matters on a level with that of the average insurance agent or broker with whom they deal. It will not raise them to the level of the highly trained and experienced professional insurance manager, nor will it raise the knowledge and understanding of the average insurance agent or broker to the level of the underwriters and claims adjusters.

The book does a good job of explaining the standardized form of policies which are customarily offered by all companies that write the particular kinds of insurance. However, what it does not do, and what no similar textbook can do, is to fit the standardized policies to the particular, and sometimes peculiar, operating conditions of an individual hospital. Neither can it explain why in two comparable cases one hospital may have broader coverage than another, nor why one hospital may be paying considerably more premium for the same insurance.

I did note that in the index there are several items related to boiler and machinery insurance which refer to Section 4-179, but in the copy of the book sent to me, the section paragraphs jump from 4-173 to 4-180, indicating omissions. Incidentally, the subject of boiler and machinery insurance as discussed in this book is more notable for what has been omitted from the discussion than for what has been included. In my judgment this is the least helpful section of the book.

No doubt the committee responsible for the preparation and publication of this book has been wise in omitting reference to the advantages offered by some companies and not by others in the competitive markets. The competition is increasing instead of diminishing, and a knowledge of how best to prepare the essential facts and figures to be presented to the underwriters and where to go to get the best results is what separates the

Ph.D.'s from the high school graduates among both the insurance buyers and the insurance agents and brokers.—DWIGHT W. SLEEPER.

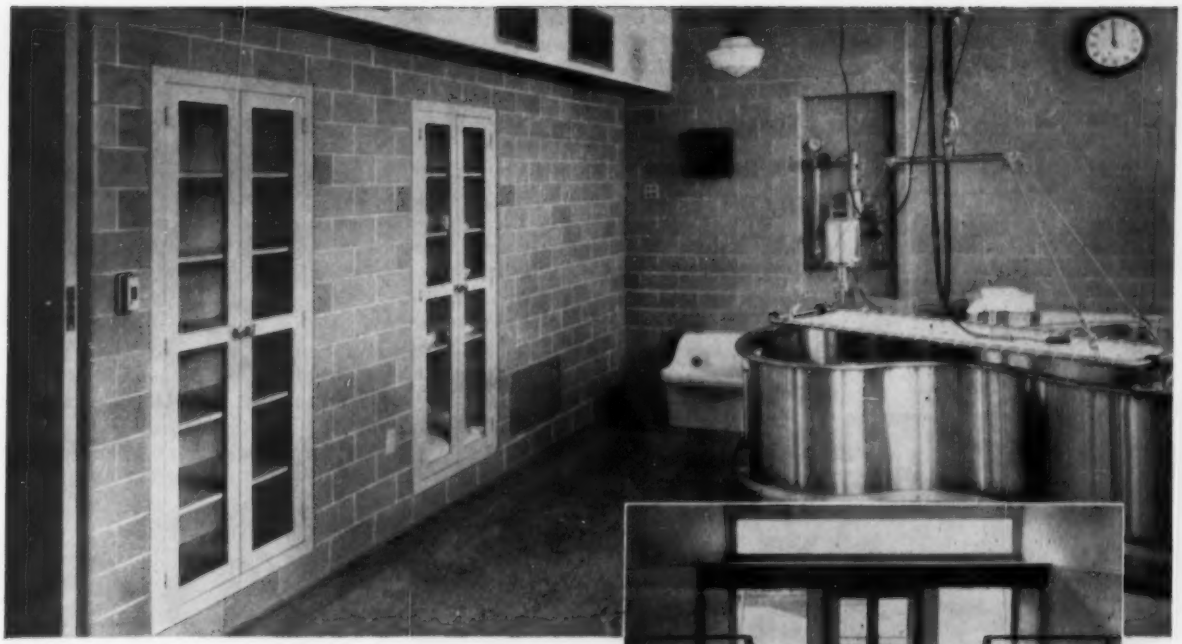
STUDIES IN THE FUNCTIONS AND DESIGN OF HOSPITALS. *The report of a team sponsored by the Nuffield Provincial Hospital Trust and the University of Bristol. Pp.* 185.

The report under review is an illustrated volume of 185 pages. The title of the report implies that the design of hospitals must follow its functions. This may be news to those in our profession who resent the discipline of function and who would reverse the logic by *making* function fall in line with "design." Nevertheless, I hope, in my lifetime, to see Frank Lloyd Wright design a hospital after "firing all the experts" because I cannot suppress the desire to see if the magic of an esthetic approach would make a good hospital.

This volume is just the beginning. Research is infinite and involves experimentation. It is rather difficult to experiment with the existing structures of the English hospitals because most of them have been built in accordance with the standards set by Florence Nightingale in Queen Victoria's days. These involve a series of closely spaced long pavilions connected by a corridor. In the usual 30 bed ward, the beds are ranged 15 to a side with heads against the outside walls which are pierced by high, narrow windows occupying the intervals between the beds.

In consequence of these conditions the investigation which culminated in the present book concerned itself largely with reviewing hospital planning literature in the U.S., Switzerland, France and Sweden. Much observing and conferring were done in England not only with persons connected with hospitals, but with various research institutions that have bearing on building in general. The investigation came to certain tentative conclusions which are set down at the end of each chapter. These conclusions were then used as guides in the design of "ward blocks" additions to two old hospitals in England. Even before proceeding with the designs, they experimented with a full size mock-up of a hospital room.

Obviously the study needed architectural participation and so it is pleasant to note that the investigating team of 12 persons had at its head the



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distinguished architect, Richard Llewelyn Davies, whom many in the hospital field in this country met when he attended the American Hospital Association convention in 1954. In addition, there were two other architects, one doctor, one nurse, plus research assistants and others with various specialties.

The time and space studies are well documented as are the space comparisons between the proposed hospital (research) additions and several well known examples in England and abroad.

Insofar as the inpatient portion of the hospital is concerned, the investigation concentrated its studies on the nursing unit, referred to in England as the ward, and on the design of hospital additions to be used for later experimentation. These additions, now being built, are also primarily nursing units.

In terms of English precedent, what is being proposed is veritably revolutionary as compared with even "up-to-the-minute" Florence Nightingale, at least in respect to the abolition of the 30 bed room and the placing of the beds parallel to the outside wall instead of perpendicular to it. In terms of what is being currently planned in the U.S., the proposed nursing units strongly resemble the hospitals for the indigent we planned for the Department of Hospitals in the City of New York in the late Thirties. What are referred to as four and six bed rooms are really open alcoves which frequently face each other. On the other hand, 25 per cent of the beds are in single rooms which are assigned to patients on a "medical and social" basis, but which may be occupied by the well-to-do at extra payment, provided they are not needed by those who are not making extra payment.

The philosophy behind the nursing unit plans is simple and direct. It says in effect that hospitals exist to make sick people well. The best way to make the patient well is to make him as accessible as possible to doctor and nurse. This explains the open plan designed so that nobody is hidden in a room if he need not be. It also explains the division of the nursing unit into small groupings so that the patients will be only a few steps from the center (the nursing station) and within sight of it. This is, of course, quite different from the point of view of our voluntary and proprietary hospitals where the paramount consideration is the operating budget. In order to stay within that budget, we strive to provide ever more private-private accommodations and innumerable services, diversions and conveniences not unlike the best hotels and resort establishments. Who knows who is right?

Actually the designs are gracious and spacious and by all appearances should be more pleasant than most rooms-strung-along-the-corridor plans.

Two things intrigue me about the affirmations concerning the nursing unit. First, subject to other controlling factors, there is no such thing as an optimum size. The problem is resolved by the simple device of sizing the complement of nurses and other personnel to the number of patients to be cared for, and the larger the unit the more economical it is in terms of personnel. The other point is that after careful evaluation the investigation gives its blessing to the six-bed room for which act I have been frequently considered kin to a savage. Accordingly, while the first experimental unit is based on the four-bed alcove, the second is based on six beds. (*Cont. on Page* 182)

(*Continued From Page* 180)

I cannot refrain from criticising the manner in which stairs are used in the first experimental building (I presume in obedience to a pseudo esthetic consideration) to block the ends of the nursing unit, depriving it of view, light, air and possible future expansion. In the second building this defect is corrected.

The investigation also studied the operating suite (theater). One of the experimental buildings will have a suite of two operating rooms built on the new plan which is also a radical departure from English precedent. It resembles the U.S. prototype, but actually lies between the elaborate European precedents where adherence to technics is enforced by physical arrangement, and the U.S. plan which leaves aseptic technics largely to the discipline of the operating suite personnel.

The study of the outpatient service is the best we have seen and those of us who do not wish to design by guess or by taking someone's word for it will find this chapter most valuable.

The chapters on the physical environment within the hospital are generally interesting, but would be considered rather primitive as compared with our best practices in the design for control of sound and the mechanical trades, such as heating and ventilating, fire protection, and so forth. The most valuable section in this chapter presents some interesting ideas on daylighting.

The chapter titled "Some General Considerations Affecting Design" is perhaps the weakest. It is understandable as an effort to say at least something on such important topics as orientation, external noise and architectural character, but I am confident that subsequent investigations will really come to grips with these topics.

Curiously the chapter, "Planning to Meet the Demand," or as we would say "Measuring the Need," comes at the end of the book rather than at the beginning as would be normally expected. This, of course, is really a clear indication of the intent of the whole book. It is not meant to be a pompous pronunciamento to settle all hospital problems once and for all, but an intelligent and, to me, an inspiring beginning.—ISADORE ROSENFIELD.

THE OPERATING ROOM SUPERVISOR AT WORK. *By Edna A. Prickett, B.S., R.N. New York: National League for Nursing. Co-sponsored by American Hospital Association.* 1955. *Pp.* 112. $1.50.

Here at last is a complete and concise picture of the management of the operating room for the operating room supervisor. The author thoroughly discusses the many complex problems which the operating supervisor alone is called upon to solve. These problems are characteristic of both the small and the large hospital.

The contents include:

1. Organization. This chapter describes general principles relative to the operation of the hospital, nursing department, and operating room.

2. Nursing service personnel in the operating room. The author discusses functions, responsibilities and qualifications of professional and nonprofessional personnel.

3. Staffing the operating room. A staffing pattern and guides for planning the staffing pattern are most adequately described.

4. Internal and external relations. In this chapter the author discusses

relationships within the operating room, within the nursing department, and with other hospital departments.

5. Controls. Under this heading comes information regarding committees, manuals, inventories, records and reports, budget and legal aspects.

6. Supervision. The author discusses functional elements, supervisory activities, assignment of personnel, observation of crucial proceedings, and educational programs.

7. Architectural planning. Included in this chapter are pertinent questions regarding physical factors, space, technics, material and equipment, services related to other hospital departments, surgical staff, personnel and patients.

8. Appendices. Here are "samples" of job descriptions. A method of calculating direct nursing service requirements for one week in the operating room, hospital personnel policies, preoperative check lists, evaluation reports, and inventory.

9. Bibliography. This includes a complete list of manuals, periodicals, books and films.

This book is one which every operating room supervisor will find most valuable. It contains a wealth of material, clearly and simply presented. The author has done a magnificent piece of work, not only in evaluating the many problems of operating room supervisors, but also in offering advice and methods of solving them.—DOROTHY C. GALLOWAY.

HOUSEKEEPING FOR HOTELS, MOTELS, HOSPITALS, CLUBS, SCHOOLS. *By Grace Brigham. New York: Ahrens Publishing Co., Inc.* 1956. *Pp.* 172. $4.75.

The title implies that the author has written about housekeeping for various types of institutions. The front flyleaf affirms this implication and classifies the book as "a complete manual and a practical guide covering every phase of housekeeping on a large scale." This, to me, is a misconception. In the preface the author herself states: "Naturally, this book can cover only basic functions and a few variations in method."

In Part I, "The Housekeeper's Duties," Mrs. Brigham describes the duties of a working housekeeper in a small hotel, then swings into a description of the executive housekeeper.

The chapters on "Recruiting," "Hiring and Orientation," "Job Analysis and Specification," "Training," "Personnel Relations" and "Job Evaluation" are expertly written and contain valuable information applicable to all institutional housekeepers.

Parts III, IV and V, covering "Organization and Management," "Furnishings," and "Principles of Decoration," and even the glossary, slant—not "somewhat" as the author states, but "definitely"—toward the hotel field, which is natural considering the author's vast knowledge and experience in hotel housekeeping.

The book contains 172 pages of sound information on well chosen topics that will be valuable to the hotel housekeeper in its entirety, and to the hospital housekeeper in part. However, I believe that housekeepers in all fields would derive great benefit from reading this new book on housekeeping.

The final chapter, in which the author ably presents the qualifications, experience and educational requirements necessary for executive housekeepers, should inspire all of us to exert greater effort toward reaching our desired goal of higher educational standards for future housekeepers.—MADGE H. SIDNEY.

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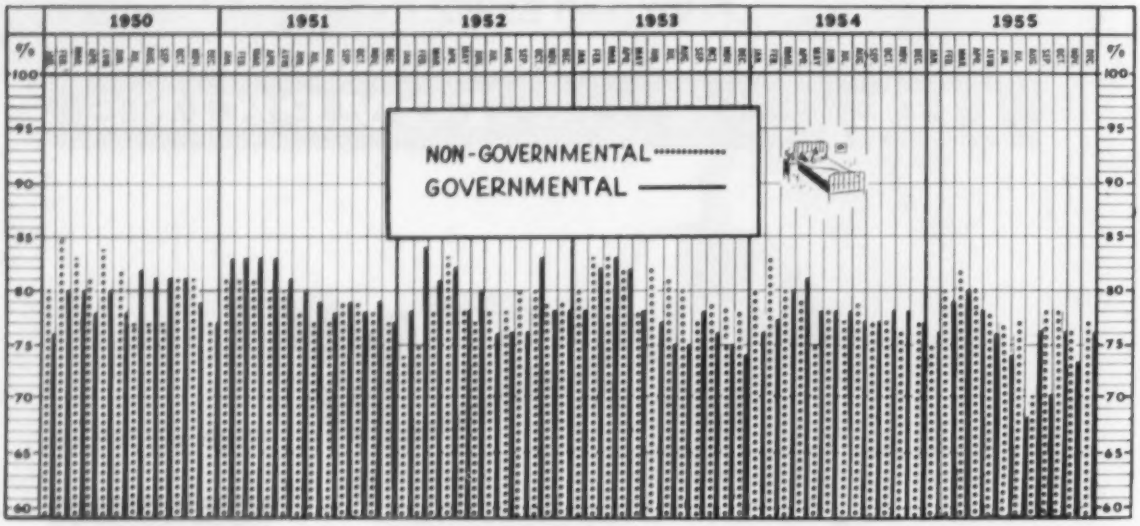

In their reports to the Occupancy Chart for the month of December 1955, government hospitals reported occupancy at 75.6 per cent of capacity —up 0.7 per cent from their December 1954 occupancy. Voluntary hospitals reported occupancy at 77.1 per cent of capacity—a 3.2 per cent increase over December 1954.

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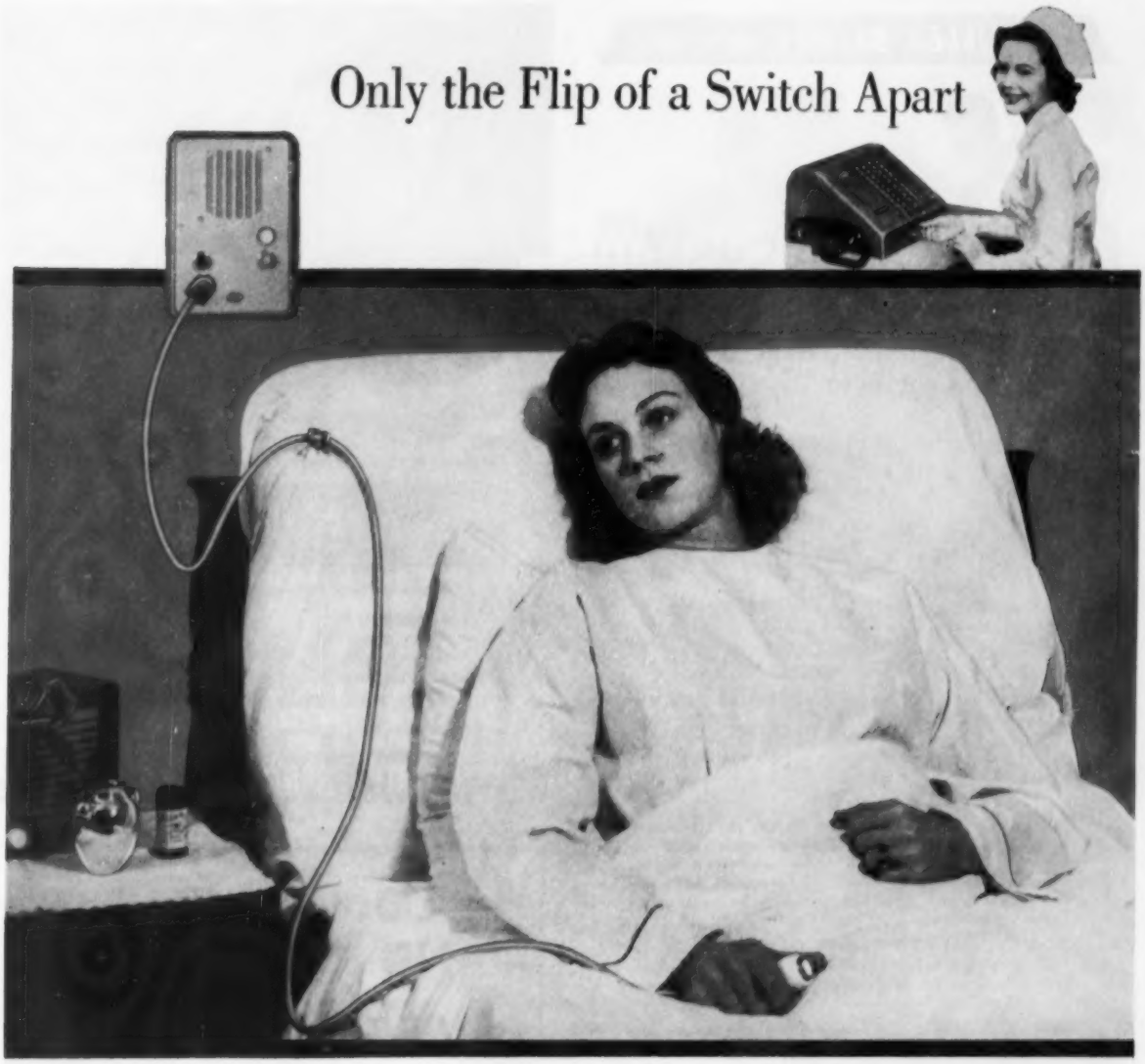

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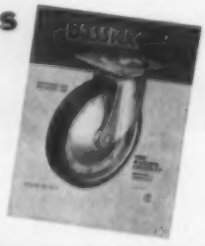

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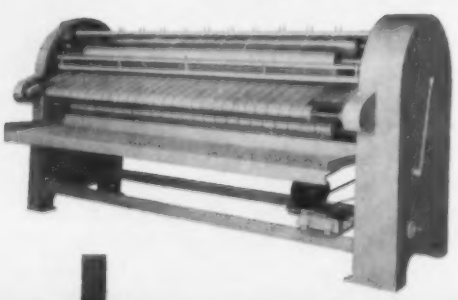

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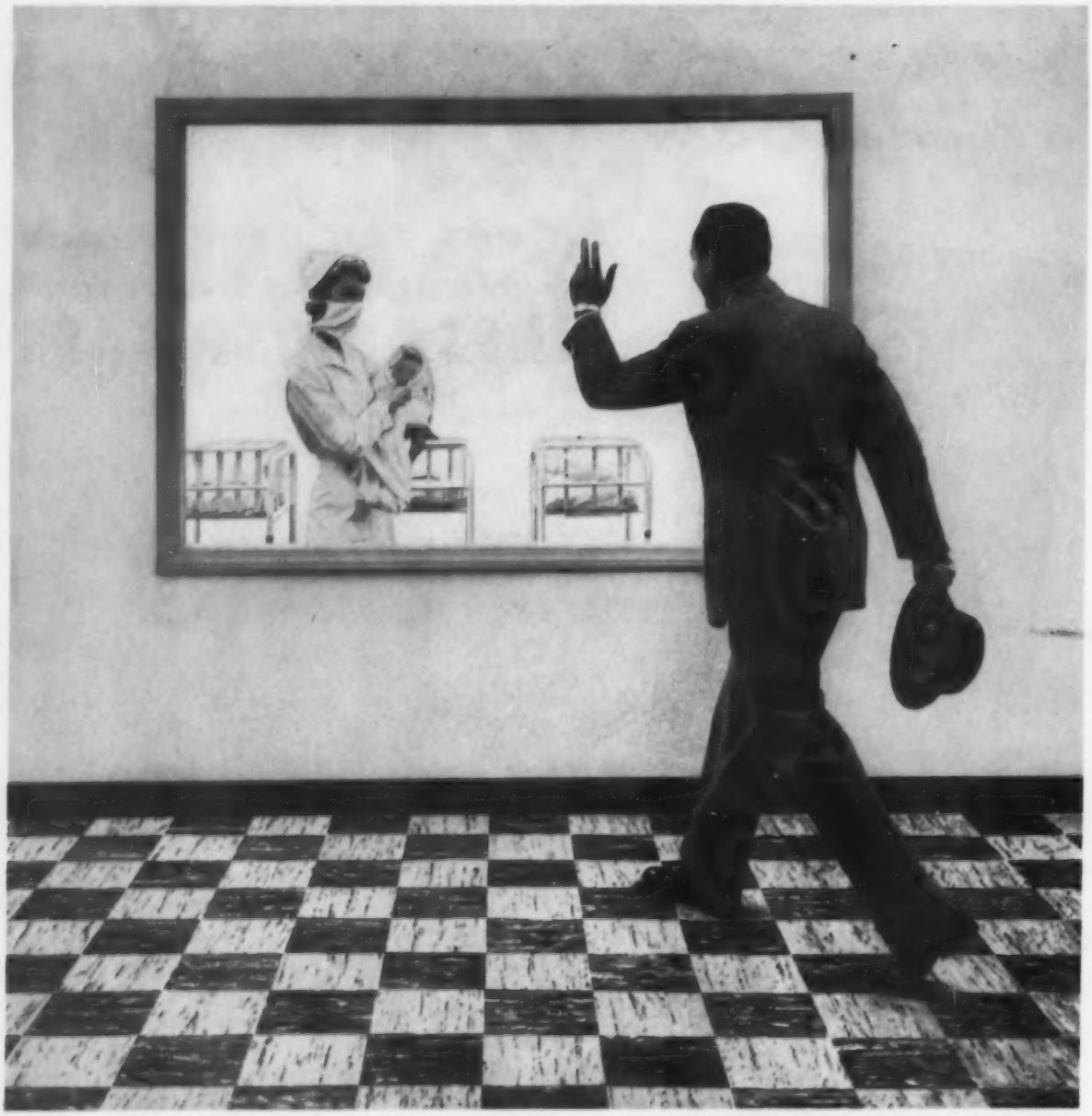

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(Continued on page 194)

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(Continued on page 196)

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LIBRARIAN—Medical records; registered or eligible for registration, to assume charge of records room; new general hospital of 150-beds and 30 bassinets; salary open; Apply giving outline of education and experience to: Executive Director, Miriam Hospital, 164 Summit Avenue, Providence 6, Rhode Island.

LIBRARIAN — Medical record — registered; to assume charge of record room; 110-bed general hospital; salary open. Contact M. I. Clement, Saratoga General Hospital, 15000 Gratiot Avenue, Detroit 5, Michigan.

LIBRARIAN—Medical record; registered; to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Registered medical record; for 212-bed general teaching hospital. Contact Assistant Administrator, Mt. Sinai Hospital, Minneapolis 4, Minnesota.

MEDICAL DIRECTOR—North American graduate; five years tuberculosis experience, relatively new 100-bed tuberculosis hospital; salary $10,000, complete maintenance. Apply State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

MISCELLANEOUS — Assistant Director in charge of surgical nursing; salary on inquiry; Administrative supervisor, obstetrics, pediatrics, psychopathic (in-service training program) chest, dermatology, urology; salary $380-415 per month; 40 hour week; differential afternoon and night 17 cents per hour; single room nurses residence $20 and $25 per month. Apply Director, Cook County School of Nursing, Department M, 1900 W. Polk Street, Chicago 12, Illinois.

(Continued on page 198)

QUIET *Care for Convalescents*

Hospital officials know that proper care during the recuperative period is every bit as important to the patient as medical and surgical treatment. The atmosphere must be pleasant . . . and *quiet*. Countless hospitals across the nation are achieving such a desirable environment with the help of Acousti-Celotex Sound Conditioning.

Two-Way Solution—A sound-absorbing ceiling of Acousti-Celotex Tile solves the noise problem with a double-duty answer: It provides a pleasing new appearance for rooms. And, most significant, it serves to check disturbing noises of voices, footsteps, elevators, dishes and trays from echoing in corridors, lobbies, kitchens, utility rooms . . . stops them from filtering into wards, nurseries, operating and delivery rooms. Patients' progress and staff efficiency are considerably aided by *quiet comfort*.

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This Costs You Nothing—You do not pay one cent for the most important part of Acousti-Celotex Sound Conditioning—*30 years of sound engineering experience*—in acoustical installations in hospitals and elsewhere. **Mail Coupon Now** for a Sound Conditioning Survey Chart that will bring you a *free analysis* of the noise problems in your hospital, plus a free booklet, "The Quiet Hospital."

Corridor of Florence Crittenden Hospital, Detroit, Mich., showing attractive ceiling of incombustible Celotone® mineral fiber tile. The Acousti-Line® Suspension System used here permits immediate access to utilities in any area above the ceiling. Acousti-Celotex Contractor: R. E. Leggette Co.

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Products for Every Sound Conditioning Problem—The Celotex Corporation, 120 S. LaSalle St., Chicago 3, Illinois • **In Canada:** Dominion Sound Equipments, Ltd., Montreal, Quebec.

Mail Today!

The Celotex Corporation, Dept. G-26
120 S. LaSalle St., Chicago 3, Illinois

Without cost or obligation, please send me the Acousti-Celotex Sound Conditioning Survey Chart, and your booklet, "The Quiet Hospital."

Name _____ **Title** _____

Hospital _____

Address _____

City _____ **County** _____ **State** _____

classified advertising

POSITIONS OPEN

MISCELLANEOUS — Openings for Operating room supervisor, Assistant head nurses and general duty nurses; liberal personnel policies. For complete information write Director of Nursing, Methodist Hospital, Henderson, Kentucky.

MISCELLANEOUS—Opening new addition; need Registered surgical anesthetist, ASCP Lab technician, Operating room nurses, Obstetrical supervisors, Obstetrical nurses, Medical nurses, Nurse supervisors, Nursery supervisor, Director of nursing education; salary open; 210-bed hospital; very good personnel policies, city of over 60,000. Write Personnel Department, Sioux Valley Hospital, Sioux Falls, South Dakota.

NURSES—Florida; take advantage of Florida's sunshine and pleasant living; Jacksonville's rapid growth has created a need for more hospital beds. Registered nurses are needed for surgical obstetrical and general duty; modern 375-bed general hospital on the beautiful St. John's River; basic salary $241.00 per month with increments for evening and night duty and for surgical nursing; 40 hour week. Apply Director of Nursing Services, St. Vincent's Hospital, Jacksonville, Florida.

NURSES—General duty; for 80-bed hospital in picturesque Trinidad, Colorado; $250-$270 per month, periodic increases, sick leave, vacation and holidays paid. Contact Director Nursing Service, Mt. San Rafael Hospital, Trinidad, Colorado.

NURSES—General duty; in all services including psychiatry; salary $273.43 to $306.80 monthly; bed capacity 1125; under civil service; above average personnel policies; forty-hour week; liberal vacation, holidays, sick leave and social security coverage; uniforms laundered; medical and hospital care provided; single rooms and meals available at nominal cost. Write Director of Nursing Service, St. Louis City Hospital, 1515 Lafayette Avenue, St. Louis 4, Missouri.

NURSES—General duty; for a 34-bed general hospital located in a winter and summer recreational area; an accredited hospital; 40 hour week, vacations, sick leave, holidays. Apply to Superintendent of Nurses, St. John's Hospital, Jackson, Wyoming.

NURSES—Graduate; two; if interested contact Medical Director, Florida State Hospital, Arcadia, Florida.

NURSES—Head surgical and staff; for 50-bed new hospital, latest equipment; positions open now; attractive salary, living expenses reasonable. Apply St. Joseph's Hospital, Del Norte, Colorado.

NURSES—Operating room and obstetrics; California hospital on San Francisco Bay, 40 minutes from that city, 5-day week, salary $305 per month if applicant has advanced preparation or experience, $10 additional for evening and night duty, maintenance available. Apply Director of Nursing, Alameda Hospital, Alameda, Calif.

NURSES—Operating room 7-3 and general duty 3-11; small specialized EENT hospital; 21-beds; top starting salary. Apply Mrs. Robinson, Administrator, Los Angeles Eye & Ear Hospital, 500 S. Lucas Avenue, Los Angeles, California.

NURSES—Operating room; 300-bed hospital, 40 hour week; all cash salary-bonus for on call; special consideration for experience and advanced preparation; social security and retirement plan. Apply Director of Nursing, Mercer Hospital, Trenton 8, New Jersey.

NURSES—Operating staff; good personnel policies for Buffalo General Hospital. Apply Mrs. Aileen L. Carroll, Director of Nursing.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

(Continued on page 200)

classified advertising

POSITIONS OPEN

NURSES — Operating room; immediate appointments; 511-bed newly enlarged and finely equipped hospital; ten operating rooms now completed; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial and educational friendly activities; living cost reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly and considerate working associates and conditions; progressively advanced personnel policies; starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5678.

NURSE—Operating room; 40-bed general hospital; modern equipment, cooperative staff; extra pay for on call; pleasant working conditions in attractive city, 25 miles south of Akron. Apply Dunlap Memorial Hospital, Orrville, Ohio.

NURSES—Registered; general duty, clinic, surgical; small general hospital; excellent working conditions. Apply MO 128, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; for newly opened 85-bed general hospital located in northern portion of Los Angeles County; basic salary: $250 with $10 per month differential for 3-11 and 11-7 shifts, 40 hour, 5 day week; positions available in all departments. Apply Director of Nurses, Antelope Valley Hospital, Lancaster, California.

NURSES—Registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES—Registered staff; for general hospital with new addition nearing completion; starting salary $260.00 per month plus one meal; $25.00 per month differential for evening and night duty; 40-hour week, 21 days paid annual vacation; sick leave and hospitalization benefits; 6 legal holidays. Write Director of Nursing Service and Nursing Education, St. Luke's Hospital, 5535 Delmar Blvd., St. Louis 12, Missouri.

(Continued on page 202)

NURSE — Registered; for 50-bed tuberculosis hospital in Indiana college town; salary $325.00 per month. Excellent working conditions; liberal vacation and sick leave. Address applications to Superintendent Smith-Esteb Hospital, Richmond, Indiana.

NURSES—Registered; 150-bed general hospital with new 75-bed addition to open January 1, 1956, in fabulous Las Vegas; starting salary $250 a month with $15 increase after 3 months; annual increments, vacation and sick time; excellent climate. For further information write Southern Nevada Memorial Hospital, Las Vegas, Nevada.

NURSES—Registered staff; age 21-45; three year graduates preferred; 45-bed general hospital; partly segregated services; congenial medical staff; rotating shifts; $252.50 a month base pay; $15.00 differential for evenings and nights; eight paid holidays; fourteen days paid vacation, twenty-one days after three years; retirement plan; other liberal personnel policies; beautiful nurses home with television; $20.00 monthly full maintenance; town of 9,000, surrounded by mountains; desirable climate year round. Apply Director of Nurses, Miners' Hospital of New Mexico, Raton, New Mexico.

NURSES—Registered; for general duty in the 100-bed private section of Rhode Island Hospital; 40 hour week, rotation duties; good personnel policies; living in if desired. Apply Nurse Director, Jane Brown Hospital, Providence 3, Rhode Island.

Why don't you talk to the men at Cumerford about raising the money?

This is a model of a new hospital that's going up soon in one corner of a large metropolitan area. You know the story—rapid growth—people moving in—NO hospital.

So they called in the men at Cumerford. The situation was surveyed. A favorable survey report indicated immediate action—and now the money is in hand and the architects are detailing the new structure. The men at Cumerford can do the same for you!

Why don't *you* talk to the men at Cumerford about raising the money?

A letter or a telephone call will bring a Cumerford representative to you for a conference on your fund-raising problems . . . and at no cost or obligation to you. Cumerford, Incorporated, America's *growing* fund-raising consultants, 912 Baltimore Avenue, Kansas City 5, Missouri. BAltimore 1-4686.

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POSITIONS OPEN

NURSES—Registered staff; immediate appointments; 511-bed newly enlarged and finely equipped general hospital; duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial, and educational friendly activities; living costs reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly, cooperate work relations and conditions; progressively advanced personnel policies. Starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

NURSES—Registered; for new 40-hour hospital located in Texas vacation land, near large cities; all shifts; excellent salary and personnel policies. Write Administrative, New Braunfels Hospital, Inc., New Braunfels, Texas.

NURSES—Registered; for operating room and general floor duty. Two general floor supervisors—one for 3-11 and one for 11-7. Apply, Martinsville General Hospital, Martinsville, Virginia.

NURSES—Registered; for surgery; 5 day, 40 hour week, starting salary $260, paid vacation, holidays and sick leave; social security and medical care program. Apply Gladys Wark, R.N., Director of Nurses, Cowlitz General Hospital, Longview, Washington.

NURSING—MISCELLANEOUS; Nursing positions available in large municipal hospital: (1) Supervisor, Nursing Service, general hospital, afternoon and night; (2) Supervisor and Instructor, psychiatric nursing, day and night. Salary $325.22 to $368.98 monthly. Bed capacity 1125; under civil service; above average personnel policies; forty-hour week; liberal vacation, holidays, sick leave and social security coverage; uniforms laundered; medical and hospital care provided; single rooms and meals available at nominal cost. Write Director of Nurses, St. Louis City Hospital, 1515 Lafayette Avenue, St. Louis 4, Missouri.

NURSES—Staff; eligible for registration in California; for 530-bed tuberculosis hospital situated in the foothills of Sierras between Sacramento and Reno on Highway 40; starting salary $300, increment to $330, differential of $10 for P.M. and night; 15 days paid vacation, 7 holidays, sick leave benefit, social security. Apply to Director of Nurses, Weimar Joint Sanatorium, Weimar, California.

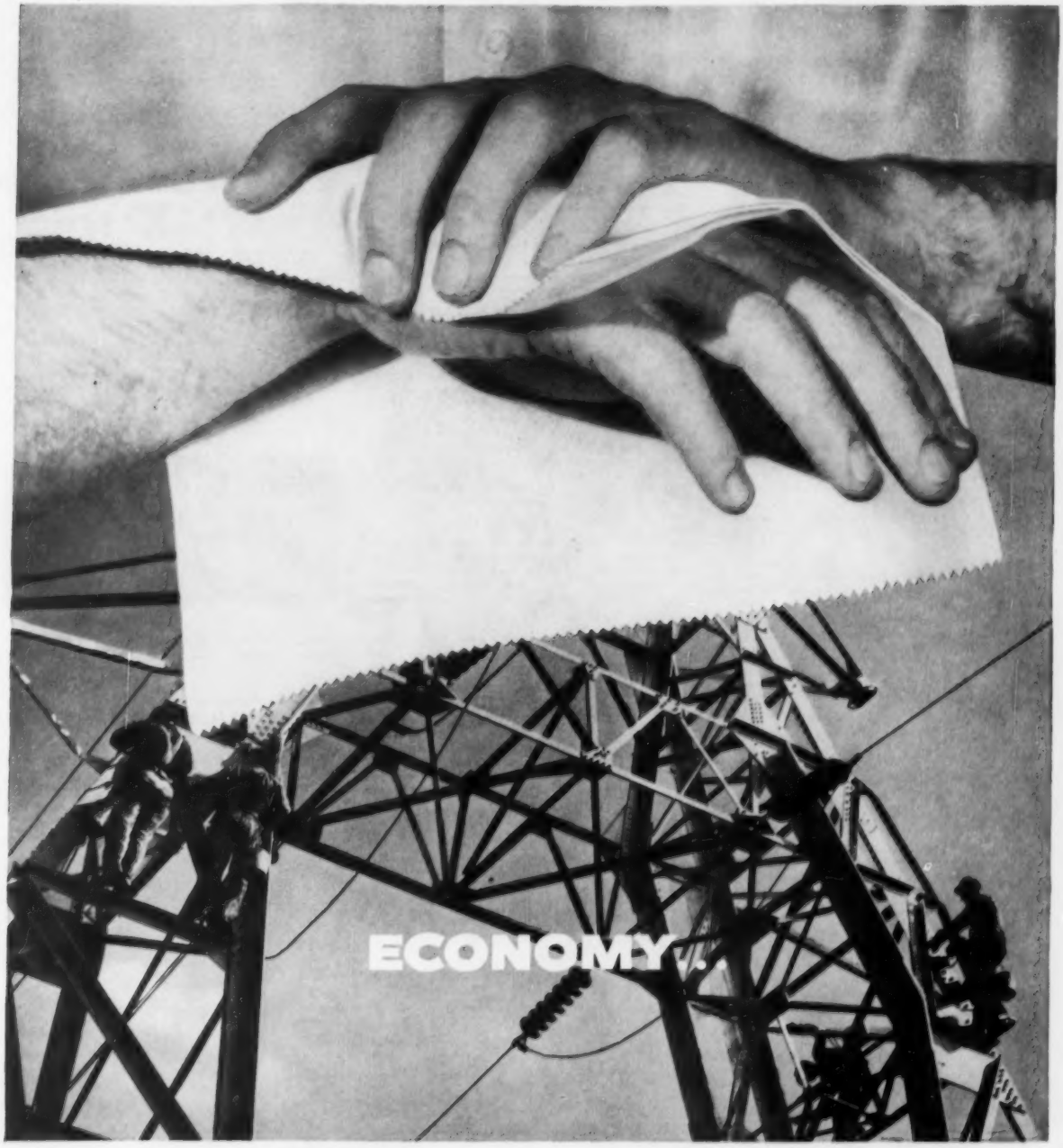
(Continued on page 204)

NURSES—Staff; admitting, clinic, chest, communicable disease, E.E.N.T., fracture, medical, neurological, neuro-surgical, nurses' infirmary, obstetrics, O.R., orthopedics, pediatrics, practical nursing training program, psychopathic, surgical, urology; beginning salary $305 and $315 per month; 40 hour week; differential afternoon and night 17 cents per hour. Apply Director, Cook County School of Nursing, Department M, 1900 W. Polk Street, Chicago 12, Illinois.

PHYSICAL THERAPIST—Experienced; registered to supervise new department in 129-bed general hospital; salary and maintenance open; excellent opportunity. Write to Director, North Adams Hospital, North Adams, Mass.

SUPERINTENDENT OF NURSES—General non-profit hospital; 201-beds; approved school of nursing, 70 students; salary open. For details write Superintendent, Norfolk General Hospital, Norfolk, Virginia.

SUPERVISOR—Obstetrics; modern 385-bed, non-sectarian general, private, hospital; 54-bed very active obstetrics unit, NLN accredited school of nursing; supervision of birth rooms, post-partum and nursery; 40 hour week, 15 days vacation, 10 days sick leave; degree preferred, not essential if experienced or with a post-graduate course; salary open. Apply Director of Nursing, Jewish Hospital, Cincinnati 29, Ohio.



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SUPERVISOR—Central sterile supply; should be well-grounded in modern techniques; new hospitals opening in Kentucky, Virginia and West Virginia in early fall; good personnel policies, 40 hour week, 4 weeks paid vacation, a non-contributory retirement plan; salary range $370-$445. Apply to Mr. Philip J. Olin, Miners Memorial Hospital Association, 1427 Eye Street, N.W., Washington 5, D.C.

SUPERVISOR—Obstetrics; post graduate work in obstetrics and supervisory experience required; immediate opening; modern and up-to-date department; social security and excellent personnel benefits. Apply Director of Personnel, White Cross Hospital, 700 North Park Street, Columbus 8, Ohio.

SUPERVISOR—Operating room; modern 400-bed hospital; well qualified person needed; salary commensurate with experience; liberal personnel policies. Apply Superintendent of Nurses, York Hospital, York, Pennsylvania.

SUPERVISOR—Operating room; 250-bed general hospital; advanced preparation necessary; capable of assuming teaching responsibility; optional 44 or 40 hour week, salary open. Apply Northwest Texas Hospital, Amarillo, Texas.

SUPERVISOR—Obstetrics; for 117-bed JCAH fully approved hospital located in the Shenandoah Valley of Virginia; modern and well equipped obstetric department; hospital affiliated with school of practical nursing; salary open. Apply Director of Nurses, King's Daughters' Hospital, Staunton, Virginia.

TECHNICIANS—Laboratory; openings exist in modern laboratory; good salary and working conditions. For further details apply to Mr. C. V. Wynne, Administrator, Waterbury Hospital, Waterbury, Connecticut.

TECHNICIANS—Registered laboratory; 265-bed teaching hospital located on Chicago's near north side, modern laboratories, starting salary $300.00 a month, alternate 5 and 6 day week, merit increases, excellent employee benefits, including 4 weeks vacation, 12 days paid sick leave, laundry furnished and a 50% tuition reduction on courses at Northwestern University. Apply Personnel Relations Department, Passavant Memorial Hospital, 303 East Superior Street, Chicago 11, Illinois.

TECHNICIANS—Laboratory; male or female. Apply The Peninsula General Hospital, Salisbury, Maryland.

TECHNICIAN—Laboratory, X-ray and nurse anesthetist; 34-bed general hospital; two doctors on staff; 5 day week; good personnel policies; summer and winter recreational area. Apply Administrator, St. John's Hospital, Jackson, Wyoming.

TECHNICIANS—Laboratory and physical therapy technicians; for 55-bed hospital in scenic Wyoming; climate ideal, pleasant working conditions, excellent facilities, splendid community. Apply Administrator, W. R. Coe Memorial Hospital, Cody, Wyoming.

TECHNICIANS—Laboratory; two, including the position as head technician, for a 245-bed general hospital. For details contact Charles Chesner, M.D., St. Joseph Hospital, Lorain, Ohio.

TECHNICIAN—Chief, laboratory; must be registered with ASCP; modern and well equipped laboratory; 220-bed hospital; salary open. Write Director of Personnel, Thomas Dee Memorial Hospital, Ogden, Utah.

TECHNOLOGIST—Medical; preferably M.T. (A.S.C.P.) for 200-bed hospital in college town; rotating service; new laboratory; good personnel policies. Apply Middlesex Memorial Hospital Laboratory, Middletown, Connecticut.

ADMINISTRATORS—(a) Medical director to take complete charge medical activities and exercise general administrative direction over business affairs of 400-bed hospital; California. (b) To direct new hospitals; medical care program of large industrial organization; mod-

(Continued on page 206)

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

ern throughout; very substantial remuneration; increases; retirement program. (c) Medical; responsibility educational program and coordinating all medical aspects of 500-bed general voluntary hospital; east. (d) Medical or non-medical; voluntary general hospital, 160-beds; man in 40's with good experience; large city, university medical center; opportunity pleasant living; New England. (e) Assistant administrator; 350-bed voluntary, general hospital, medical school affiliated embarking on huge expansion program; attractive offer to experienced man; town 100,000; east. (f) Assistant director; university hospital, large size in dynamic hospital setting; requires several years experience, preferably one ACHA; $8500; recommended.

ADMINISTRATORS—Women—(a) R.N. or non-medical; general hospital 40-beds, to be constructed shortly; Los Angeles area. (b) R.N. or non-medical; well equipped 60-bed general hospital; accredited, with comprehensive diagnostic services and interesting expansion plans; lovely New England tourist resort town. (c) R.N. or non-medical; 70 bed crippled children's hospital, converting to general pediatric institution; large southern city, industrial and university center. (d) R.N. or non-medical; 30-bed Hill Burton hospital now under construction; small midwestern community near large university city.

WOODWARD—*Continued*

ANESTHETISTS—(a) Two required; very active surgical service, 100-bed general hospital; good salary, with maintenance at low cost; lovely resort community 10,000; Pacific northwest. (b) Fully approved, 300-bed general hospital; $500; large university and cultural center; midwest. (c) Voluntary general hospital 100-beds; $500; one of Alaska's larger cities. (d) New, modern hospital 50-beds; $550 start, increase to $600 in 6 months; lovely resort community; midwest.

DIETITIANS—(a) Chief; administrative dietitian qualified assume challenging responsibility; 300-bed general hospital expanding to 500; $4500 up; large university city; midwest. (b) Three units, 300-beds; to $450; California. (c) General hospital 75-beds; also operate employee cafeteria serving 200 meals daily; to $425; lovely small community; midwest.

DIRECTOR OF NURSES—(a) Nursing service; degree required; large general hospital; to $8800; near large university city; midwest. (b) Nursing service and education; nearly 200 on nursing staff and 60 students in accredited school; 300-bed general hospital; to $7800; residential suburb, large university city; east. (c) Nursing service only; school operated under full time educational director; responsible only to administrator; large teaching hospital; $7000, full maintenance; university city; south central. (d) Nursing service; new hospital, 200-beds; staff and facilities exceptional; large progressive university city; New England.

WOODWARD—*Continued*

EXECUTIVE HOUSEKEEPERS—(a) Prefer trained in industrial techniques; must be qualified to assume full administrative responsibility; very large, medical school affiliated hospital system; $5000 minimum; resort city; southwest. (b) Full executive responsibility, 400-bed general hospital to be completed late this year; to $5400; lovely large city; south. (c) University medical school affiliated general hospital 250-beds; lovely city; Pacific northwest.

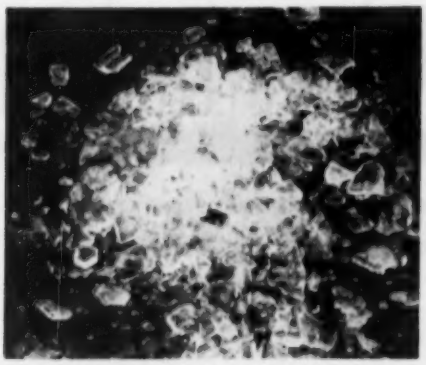
FACULTY POSTS—(a) Educational Director; small, but well established collegiate affiliated school; approved, 160-bed general hospital; lake resort community of 60,000; $6000 up; mideast. (b) Educational director; lovely southern hospital, 250-beds; attractive community 20,000; recommended. (c) Science instructor; fully approved 250-bed general hospital; residential and industrial suburb, large university medical center; east.

SUPERVISORS—(a) Obstetrics; 35-bed unit; teaching required; voluntary general hospital; 200-beds; $4200; resort town near New York City. (b) Operating room; small general hospital; JCAH approved; $4500; attractive small town; southwest. (c) Operating room; active surgical service; 6-room suite; staff of 15 in addition to students; 300-bed general hospital; excellent personnel policies; town 50,000; New England.

(Continued on page 208)

Institutions of All Sizes Find Shell-Ice Saves Money

Shell-Ice Being Blown into the Hold on a Fishing Vessel at Velasco, Texas



Shell-Ice Consists of Solid, Slightly Curved Pieces, and With Average Good Water Is Clear

HARVEST NEW PROFITS with

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Shell-Ice*

Shell-Ice Can Be Scooped, Shoveled, Bagged or Conveyed.

Pair of 20-Ton Shell-Ice Makers in Operation

This new kind of ice is frozen automatically on stainless-steel tubes—no labor, no crushing, no snow, waste or special cleaning.

Shell-Ice is ideal for use in cooling drinking water and beverages, bottled milk, fish, poultry, fruits, vegetables, displays, trucks, etc., etc. Pieces are ⅛ to ½ inch thick, as desired: ¼-inch ice is harvested every 10 minutes.

Shell-Ice Makers can be connected to your existing refrigerating system, if preferred, since they operate on direct-expansion refrigerant. Built in 12 sizes, making ½ to 30 tons of ice per 24 hours. Small floor space required. Many already installed.

Get the full facts and figures: ask for Bulletin 54 today. *Trade Mark

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POSITIONS OPEN

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Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Medical director; new 400-bed hospital for chronic and custodial patients; east. (b) Administrator well qualified in medical education; important teaching hospital; $15,000-$25,000. (c) General hospital, 275-beds, completed '53; expansion program to 400; resort city, south. (d) General 200-bed hospital; attractive residential town, New England; $10,000-$15,000. (e) New 125-bed hospital, construction to commence within few months; building experience advantageous; college town; midwest. (f) General 125-bed hospital functioning essentially as community hospital for British and American colonies in foreign country; expansion program; $12,000; cost of living ½ and 2/3 of United States. (g) General 50-bed hospital currently under construction; California. (h) Assistant director; university hospital; 800-beds; east. (i) Executive secretary; medical society, medical center; midwest. (j) Clinic manager; 15-man group; college town, west. MH2-1

ADMINISTRATORS — Women — (a) Small, modern hospital; well organized, English-speaking staff; cosmopolitan city, outside United States; housing, transportation provided. (b) Well established, 50-bed hospital; good financial status; mountain resort area, East. MH2-2

ANESTHETISTS—(a) Outside U.S.A. modern, air-conditioned, 300-bed hospital for employees of American company; $10,000. (b) Percentage or fee basis, 40-bed, new hospital, near Mexico border. (c) Head staff of 2; new 70-bed hospital; opens March; scenic resort area; $6000. (d) Small general hospital; coastal city, Alaska; $6000. MH2-3

DIETITIANS—(a) Chief; 200-bed remodeled hospital, new wing; summer resort, 30,000 area, medical center; $6000. (b) Nutrition consultant; therapeutic dietary skill; teach university medical students; excellent opportunity for advancement; key midwest city. (c) Chief; university medical setting, faculty status; department of 16 qualified dietitians and adequate complement of aides, etc.; 150,000 meals per month; $8000. MH2-4

DIRECTORS OF NURSING—(a) Assistant director; 300-bed air-conditioned hospital; American company; foreign operation; $12,000. (b) Director, school and service; 400-bed hospital; outstanding opportunity; leading university city, midwest. (c) Director; dual responsibility; 70 students; well organized nursing staff; suburban area of key industrial center, east; $7800. (d) Top-notch assistant; administration and coordination of service with accredited school of 150; beautiful city, outside United States; $8400. (e) Director of Nursing; 80-bed hospital; cooperative staff; mild year-round climate; attractive salary; southwest. MH2-5

EXECUTIVE HOUSEKEEPER—250-bed pediatrics hospital, university affiliated; planning two million dollar expansion; 50 employees in department; also charge of laundry, staff of 12; metropolitan area, east. MH2-6

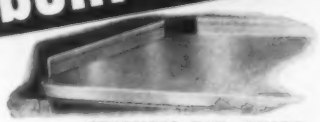
EXECUTIVE PERSONNEL — (a) Comptroller; newly created post; general hospital, 275-beds; resort city, Florida. (d) Personnel director; Master's in Personnel Administration, several years experience desired; 500-bed teaching hospital, midwest. (c) Purchasing director; 900-bed general hospital; degree, comprehensive experience required; experience industrial engineering or business management advantageous; midwest. (d) Directors, personnel and purchasing; 400-bed general hospital; university city, south. (e) Food supervisor; new position; 400-bed teaching hospital; university city, east. (f) Director, public relations; state hospital association. MH2-7

(Continued on page 210)

NEW *Ideal* MEALMOBILE with...

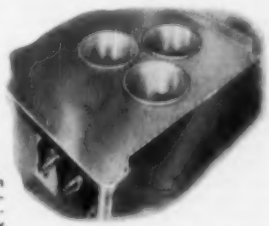
built-in BEVERAGE DISPENSER

Add speed and ease in your centralized food service system with this new unique Mealmobile. It delivers, with "kitchen-control," 20 meals of hot and cold foods . . . and dispenses both hot and cold liquids. The new Ideal Mealmobile is truly a new plus in food serving efficiency!



SEAMLESS TOP GUARD

Eliminates dirt catching crevices. Open corners permit easy cleaning. Extended edge of guard prevents articles carried on top deck from sliding off in transit.



BEVERAGE DISPENSER

Exclusive Ideal built-in beverage dispensers feature individual thermostatic control. Thoroughly insulated from each other and from the remainder of the cart, they can carry both hot and cold liquids. Each well has 5½ quart capacity.

LOCK SEAMED INSULATED DOORS

Exclusive Ideal overlapping doors provide positive seal regardless of temperature extremes. Easy to open and close. Glass fiber insulation reduces temperature change inside compartments.

SUPER SIZE DRAWERS

Seven heavy gauge stainless steel drawers in the heated section. Each holds three 9" plates plus three side serving dishes. Safety stops and name card holders.

NO-TIP TRAY GUIDES

Exclusive "no-tip" guides allow tray to be pulled out all the way and kept level for drawer-to-tray serving without lifting tray to top deck. Affords speedier service and less chance for error.

REMOVABLE TRAY GUIDES

Removable guides make entire interior easily accessible for cleaning. Guides can be scrubbed with pots and pans or run through dishwasher. Easy to clean and to keep clean.

Write for FREE catalog.

Ideal®
HOSPITAL EQUIPMENT
Found in Foremost Hospitals

Made only by the
SWARTZBAUGH MANUFACTURING COMPANY
MURFREESBORO, TENN.

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MEDICAL BUREAU—*Continued*

FACULTY POSTS—(a) Assistant professor, pediatric; two assistants; well renowned college; greater New York; minimum $5000. (b) Obstetrics clinical instructor; accredited school of 150; mild climate; beautiful city, outside United States; $5500. (c) Assistant instructor, Foundation of Nursing; 350-bed general hospital; San Francisco Bay area; $4200. (d) Director; establish nursing division; small community college affiliated with state university; west. (e) Nurse educator, Iran, $8-$10,000. MH2-8

RECORD LIBRARIANS—(a) Director; has assistant, staff of fourteen; 500-bed hospital with expansion program to 750; excellent cooperative medical records committee; one month vacation; near New York City. (b) Chief; general hospital, 165-beds; four assistants; San Francisco area. (c) Chief; general hospital currently under construction, completion fall 1956; preferably one available May to establish department; university city, south. MH2-9

STAFF, SCRUB—(a) Staff; foreign operation; outstanding American company; air conditioned hospital, living quarters; recreational facilities include private golf course, swimming pool; $7800. (b) Scrub; active surgery; 200-bed hospital; opportunity further education; near San Francisco. MH2-10

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 60-bed hospital; Wisconsin; building program. (b) 60-bed hospital, midwest. (c) 45-bed hospital; Pennsylvania.
ACCOUNTANTS—(a) 260-bed hospital, east. (b) 120-bed hospital, Ohio. (c) 250-bed hospital, west.
ADMINISTRATORS—R.N.—(a) 50-bed hospital, Wisconsin. (b) 50-bed hospital, Ohio. (c) 30-bed new hospital, Iowa. (d) Assistant; 175-bed Ohio hospital.
DIRECTORS, NURSING SERVICE—(a) 120-bed eastern hospital; salary $400. (c) 150-bed hospital, New York.
DIRECTORS, NURSING EDUCATION—(a) 180-bed fully approved hospital, near large midwestern city. (b) 225-bed hospital, south.
EXECUTIVE HOUSEKEEPERS—(a) Large teaching hospital; southwest; $5000 (male-female). (b) 175-bed Texas hospital. (c) 225-bed hospital, midwest. (d) 275-bed eastern hospital. (e) Pennsylvania; $350.
RECORD LIBRARIANS—(a) East, midwest, south; to $5750. (b) Anesthetists; $500. (c) Laboratory; X-ray technicians. (d) Physiotherapists; (e) Pharmacists.
DIETITIANS—Administrative; therapeutic.

(Continued on page 212)

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATORS—(a) Middle west; 125-bed hospital; $7000-$10,000. (b) Assistant director; university hospital rich in tradition of medical education and research; 500-beds; $8500. (c) East; R.N. preferred; 50-bed hospital; present incumbent retiring after 28 years with hospital. (d) South; 50-bed hospital, new; located in town of 10,000 close to several large cities. (f) Assistant administrator; southwest; 400-bed hospital located in large medical center; will also act as personnel director; $500 up.

EXECUTIVE SECRETARY—Middle west; well known medical group located in city of 400,000. Prefer some experience in public relations; this is an excellent opportunity with a real future; $3000.

NURSING SERVICE DIRECTOR—Middle west; 210-bed hospital; school of nursing fully accredited; staff has many young progressive doctors on it who are interested in teaching student nurses; located in city of 300,000; $7200.


KALAMAZOO GAZETTE

HOME EDITION

BRONSON GIFTS REACH $1,383,597

Fund Drive Passes Goal By $93,997

$1,383,597

Kalamazoo Hospital celebrates third fund-raising victory in 10 years!

Three times within the past ten years, Bronson Methodist Hospital of Kalamazoo, Michigan, has asked the citizens and industries which it serves for vitally needed capital funds. Each time, top-flight volunteer leadership and professional direction by Ketchum, Inc., have teamed up to lead this hospital to victory.

Mr. Elwood H. Schneider, President of the Board of Trustees, stated following the most recent campaign: "Your representatives gave our campaign marvelous direction . . . I can frankly tell you I have never seen a campaign with more enthusiasm at the top level than this one had."

JUST LOOK AT THIS RECORD!

1946 Expansion Fund Campaign
Goal: $800,000 Pledged: $1,079,097

1950 Completion Campaign
Goal: $991,000 Pledged: $1,258,060

1955 Nurses' Home Campaign*
Goal: $1,289,000 Pledged: $1,383,597

*Note that this total includes a government grant of $329,700 and a bequest of $255,000. The public goal of $704,900 was oversubscribed by almost $94,000.

We cordially invite your inquiries, at no obligation

KETCHUM, INC.
Campaign Direction

CHAMBER OF COMMERCE BUILDING, PITTSBURGH 19, PA.
CARLTON G. KETCHUM, *President* NORMAN MACLEOD, *Executive Vice President*
McCLEAN WORK, *Vice President*

500 FIFTH AVENUE, NEW YORK 36, N. Y. JOHNSTON BUILDING, CHARLOTTE 2, N. C.
H. L. GILES, *Eastern Manager* G. E. MATTISON, *Southeastern Manager*

Member American Association of Fund-Raising Counsel

classified advertising

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES

11 West 42 street New York 36, N. Y.

Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

Agency

HOSPITAL PERSONNEL BUREAU

Knickerbocker Bldg. 218 E. Lexington St.

Baltimore 2, Maryland

"LExington 9-5029"

Chas. J. Cotter, Director

(Former Administrator)

Nation-wide placement service for Physicians, Administrators, Anesthetists, Dietitians, Nurses, Technicians, Pharmacists, Comptrollers, Accountants, Secretary, Housekeepers, etc.

Mail resume, 5 photos, salary.

No Registration Fee. Licensed Employment Agent.

(formerly Hagerstown, Maryland)

ZINSER PERSONNEL SERVICE

Anne V. Zinser, Director

Suite 1004—79 West Monroe Street

Chicago 3, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

(Continued on page 214)

INDIANA MEDICAL BUREAU

212 Bankers Trust Bldg.

Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

Information about

QUALIFIED NURSE PERSONNEL

is available from the

American Nurses' Association

PROFESSIONAL COUNSELING & PLACEMENT SERVICE

37 So. Wabash Ave.

Chicago 3, Ill.

STate 2-8883

MEDICAL PLACEMENT SERVICE

Mrs. Stewart R. Roberts, Director

15 Peachtree Place, N. W.

Atlanta, Georgia

Southern Hospitals look to us for personnel. We have openings for Nurse Anesthetists, Laboratory Technicians, Nursing Directors, Dietitians. Let us help you locate the opportunity you are seeking.

American Appraisals help hospitals control property accounts

American Appraisals supplemented with continuous service to record changes in physical assets and fluctuations in value provide a sound basis for keeping hospital property records in line with changing property facts.

The AMERICAN APPRAISAL Company

Leader in Property Valuation

Home Office: Milwaukee 1, Wisconsin

DEXTER DIAPERS

Machine Packed in Osnaburg Bags

DDs COST LESS ON THE JOB THAN ANY OTHER

FOR SERVICE INSTITUTIONS

36 DOZ. PER BAG

DIRECT FROM FACTORY TO YOU!

You will have to use "Dexter Diapers" to believe them. They go on and off baby in a jiffy—without folding, save half the changing time in your nursery. In your laundry they are easier to count, wash, dry, wrap, need no folding, take up less room, last longer, cut your laundry costs right in half. They are nationally advertised in 26 publications as an institution diaper. Ask your Diaper Service Company or write direct to Dexter Diaper Factory for sample and free booklet with facts about diapering written by a famous physician.

DEXTER DIAPER FACTORY, HOUSTON 8, TEXAS

classified advertising

MISCELLANEOUS

Doernbecher Memorial Hospital, the pediatric unit of the University of Oregon Medical School, moves into its new home in the University Hospital the 1st of March. This expands the pediatric beds to 110, and the new building will also provide 150-beds for adult medical, surgical and psychiatric patients.

The hospital is situated on a hill overlooking the city just 15 minutes by bus from downtown Portland and affords a fine view of Mt. Hood and other peaks of the Cascade range where skiing is readily available.

A number of positions for General Duty and Assistant Head Nurses are available, as well as Head Nurse and Supervisory positions in some areas. For those nurses wishing further academic preparation, the Department of Nursing offers courses on the campus leading to baccalaureate and master's degrees.

For complete information write: Director of Nursing Service, University of Oregon Medical School Hospital, 3181 S. W. Sam Jackson Park Road, Portland 1, Oregon.

Established manufacturer with new line for hospitals and institutions wants REPRESENTATIVES experienced selling high quality equipment. Apply MS 14, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS

100 East 59th Street, New York City

BRAND NEW SCANLON-MORRIS 16x24 stainless steel, double jacketed, electric autoclaves, 110/220 V. AC, complete with STERO-MASTER automatic sterilizing control, $1000.00, f.o.b. Boston.

MEDICAL SALVAGE CO., INC., 217 East 23rd St., New York 10, N.Y. Murray Hill 4-4267.

FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

A BONE BANK IS NOW AVAILABLE TO ALL HOSPITALS

We will ship to any hospital an assortment of "OSTEOGEN" bone grafts for $75.00. This assortment consists of a large, medium and small bone graft. Each bone graft will have a supply of ground "OSTEOGEN" for use in bone defects, non-unions and spinal fusions, together with sensitivity test serum. For further information regarding these bone grafts write to the National Bone and Tissue Laboratories, Inc., P.O. Box 529, Houston, Texas.

(Continued on page 216)

classified advertising

FOR SALE

CUBICLE CURTAINS

Grommet or slider type. Your choice of colors and materials including jeans, twills, topsail and duck. Send list of sizes and particulars. I will furnish firm quotation and samples.

William A. McDonough
11 Glenwolde, Tarrytown, N. Y.

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

SCHOOL OF ANESTHESIA—Open to registered nurses from accredited school of nursing. Under the direction of anesthesiologist and four registered nurse anesthetists. School is approved by the American Association of Nurse Anesthetists. For information write to Kurt O. Leonhardt M.D., Director, School of Anesthesia, The Memorial Hospital, Danville, Virginia.

New Lloyd

SQUARE TUBULAR STEEL Institutional Furniture

For Quality, Styling and Heavy-Duty Serviceability

Smart, new Lloyd Square Tubular Steel Furniture creates an atmosphere of modern elegance in public or private rooms. Yet with all its expensive design features, all its quality construction and lifetime durability, this new Lloyd furniture provides practical economy . . . both in initial investment and rock-bottom maintenance cost.

- ★ Designed for full coordination with modern interiors.
- ★ Tubing custom finished in Brushed Satin Chrome or colorful baked enamel.
- ★ Square Tubular Steel construction with welded joints provides maximum strength and handsome appearance.
- ★ Upholstery coverings in rugged plastics or soft decorator-selected fabrics.
- ★ Self-aligning, rubber-cushioned floor glides for silence and ease in moving.

A wide range of coordinated pieces include settee-davenports, side chairs, sectionals and tables. All table tops feature damage-resistant plastic surfaces for wipe-away cleaning.

SEND FOR COMPLETE DETAILS, TODAY

Lloyd Manufacturing Co., Dept. MH-2
(A Division of Heywood-Wakefield Co.)
Menominee, Michigan

Please send complete information on new Lloyd Square Tubular Steel Institutional Furniture.

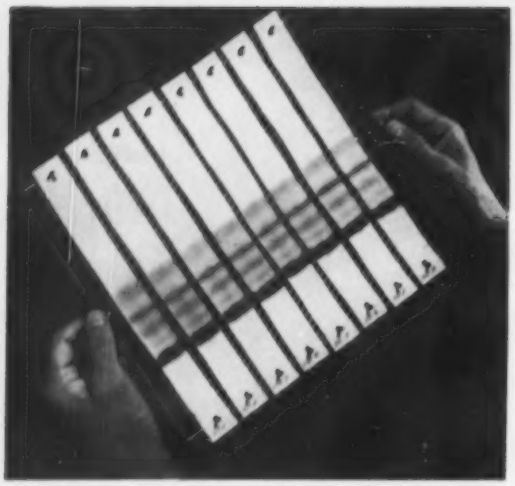
NAME .....

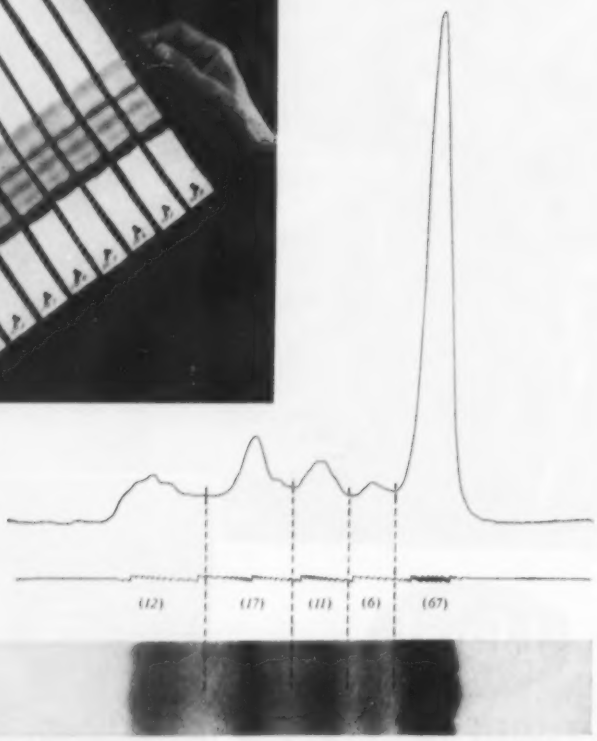
TITLE .....

COMPANY .....

ADDRESS .....

.....





RESULTS • *reproducible - rapid* • *automatically recorded*

SPINCO Model R PAPER ELECTROPHORESIS

For the first time, a complete paper electrophoresis system with coordinated features for simple routine analyses in the clinical laboratory. Every step is systematized from precision application of the specimen to final automatic recording of the relative concentrations. Ask for full details.

BECKMAN

Spinco *division*

BECKMAN INSTRUMENTS, INC.
BELMONT 2, CALIFORNIA

Equipment and Supplies Stocked by Distributors in Principal Cities throughout U. S. and Canada

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 240. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Self-Contained Unit for Mixing Barium

The Bariumette is a self-contained corrosion proof unit which is automatically controlled for mixing and dispensing centers for both warm and cool barium. The warm barium (100 degrees F) is held at body temperature for enema work. The cool barium (40 to 50 degrees F) is for oral administration. Finished with Micarta and stainless steel, the unit is compact, attractive in appearance and efficient in operation. It is capable of mixing a 1:1 solution by volume of barium sulphate in a maximum of ten minutes and then reaching the specified temperature in a maximum of 90 minutes, using the largest capacity of three gallons per unit.

The free standing construction of the Bariumette makes it independent of any walls for structural support of splash protectors, work top or sink base. Aluminum, plastic and stainless steel are used where needed for corrosion proofing. A built-in storage area at the bottom is large enough for two 100 pound drums of barium sulphate which swing out with the doors for easy access. The unit takes only 36 by 32 inches of floor space. **Westinghouse X-Ray Division, P. O. Box 406, Baltimore 3, Md.**

For more details circle #530 on mailing card.

ASR Surgical Soap Is Germicidal

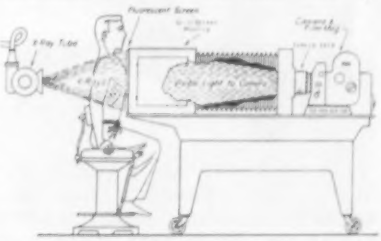
The new Surgical Cosmetic Soap introduced by ASR contains hexachlorophene, the long-acting skin antiseptic, in a soap base containing milk solids and lanolin. It has a clean, pleasant odor, is hospital green in color, and is extra mild to the skin. Resident bacterial count is rapidly lowered when the new soap is used for surgical scrubbing. A low bacterial count can be maintained continually by the daily use of the soap.

ASR Surgical Soap can be used in the hospital for ordinary use by staff and patients, for pre-operative antisepsis of the skin, and in clinics and first-aid stations. It is available in wrapped and unwrapped cakes. **American Safety Razor Corp., Hospital Division, 380 Madison Ave., New York 17.**

For more details circle #531 on mailing card.

Apparatus Available for X-Ray Motion Pictures

Cinefluorography is now available in commercial equipment, with the announcement of the first such units by



General Electric Company, x-ray department. The new apparatus for use with conventional x-ray equipment can be used for taking motion pictures with the patient seated, standing or lying down. The picture-taking area is 15 by 15 inches.

The device can be used with either 16 mm or 35 mm film and offers a speed range of 3¾ to 30 frames per second. The fast f/0.71 lens is the heart of the new device. The electronic triggering mechanism turns the 100,000 to 130,000 volt x-rays on and off up to 30 times a second, in perfect synchronism with the motion picture camera, minimizing the x-ray dosage that the patient receives. The patient sits between the x-ray tube and the camera lens and camera and film magazine, in front of a fluorescent screen.

It is stated that previous to the announcement of the new x-ray camera apparatus for commercial machines, only a few hand-built x-ray motion picture cameras were in use. The availability of the new equipment is expected to extend the clinical and research use of the technic. **General Electric Co., X-Ray Dept., 4855 Electric Ave., Milwaukee 1, Wis.**

For more details circle #532 on mailing card.

(Continued on page 220)

Pre-Heated Meals for Vending Machines

Hot foods, packaged in individual portion containers, are now offered through vending machines. A choice of 14 hot plate lunches and 13 heavy soups will be available through this new development. To obtain the hot food of his choice, the nurse or other individual simply inserts a coin in the proper slot of the machine and the meal is automatically served at a 150 degree temperature in the original container. An opener for the container and disposable spoon or fork are also made available.

Meals available through the new vending machines in the Heinz portion pack line include Chicken Noodle Dinner, Beef Goulash, Beef Stew, Lamb Stew, Chop Suey, Beans with Molasses Sauce and with Smoked Pork, Macaroni with Cheese Sauce, Chili Con Carne, Spaghetti with Tomato Sauce, Chicken Stew with Dumplings and Spanish Rice. Each vending machine is designed to carry six varieties of foods. Varieties may be rotated according to their popularity when only one machine is used at a location. The vending machines have been developed by Mills Industries, Inc., in

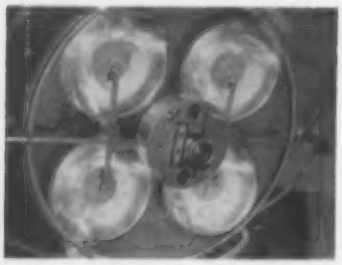
conjunction with the Heinz Company. The new service should be of interest for cafeterias, lunchrooms or nurses' homes. **H. J. Heinz Company, 1062 Progress St., Pittsburgh 12, Pa.**

For more details circle #533 on mailing card.

WHAT'S NEW

Major Operating Light Has Color Camera Attachment

Photographic equipment is immediately available in the surgery with the new Color Camera Attachment for



mounting a 35 mm camera in the lamphead of the new Castle major operating lights. The emergency device permits the taking of color transparencies for evidence or record purposes. The attachment is mounted directly in the lamphead of the new Castle No. 62 or 61 lights and houses a Kodak Retina IIIc Camera. Cameras are easily and quickly detached from the unit for other picture taking purposes.

Minor adjustments of the surgical lamphead or table superimpose built-in focusing rangefinder spotlights at the center of the field to give fine detail and perfect focus for all pictures. One control knob winds the film within the camera and cocks and trips the shutter for exposure. Lens settings are pre-set and double exposures are impossible. No additional lights or filters are required for color photography due to the regulated color-correction and intensity of the operating light. **Wilmot Castle Co., P. O. Box 629, Rochester 2, N.Y.**

For more details circle #534 on mailing card.

Powdered Cream in Individual Packets

Single serving sized packets of Pream, the instantly soluble powdered coffee cream, are now available. Pream is coffee cream in powdered form with nothing added. The new packets for individual service give positive portion control, eliminate spoilage or spillage, as well as filling, handling and washing creamers. Pream can be stored at room temperature. In the new packets it is sanitary and economical. **M & R Dietetic Laboratories, Inc., Special Products Division, 625 Cleveland Ave., Columbus 16, Ohio.**

For more details circle #535 on mailing card.

Vending Machine for Packaged Milk

A simple and easy to operate vending machine has been introduced to handle packaged milk. The new machine offers a choice of three flavors and will handle 216 half pint or one-third quart cartons. It can also be used for bottled milk. The simplified mechanism with few working parts results in simplicity of operation and servicing and reduced cost. The entire inner mechanism can be withdrawn from the vendor like a file drawer and replaced with a new unit if required. The automatic, coin operated machine is 78 inches high, 30 inches wide and 25 inches deep. **Norris Dispensers, Inc., 2720 Lyndale Ave. S., Minneapolis 8, Minn.**

For more details circle #536 on mailing card.

"Redi-Serv" Traycart for Fast Food Service

A low-cost Mealpack system is offered in the new "Redi-Serv" Traycart. It will handle service for up to 63 beds per meal in three trips with each tray instantly ready to serve. It requires no electric preheating, yet hot foods remain hot without drying out and cold foods remain cold. Trays are made up completely in the kitchen, thus avoiding the possibility of mistakes, and trays are ready to serve when the traycart reaches the patient's door. All foods for every tray are controlled at the main kitchen.

The new "Redi-Serv" Traycart is easy to clean, there is nothing to disassemble and no wiring or heating elements. The locking type sliding doors protect tray contents between the main kitchen and the serving points. The Mealpack "five point" precision caster suspension makes the Traycart easy to handle and to store. It has sanitary, sturdy construction of welded stainless steel. **Mealpack Corporation, Evanston, Ill.**

For more details circle #537 on mailing card.

Fiberglass Tray Has Non-Porous Surface

Made of fiberglass and polyester resins, the new Toteline Tray No. 459 has a smooth, non-porous surface which cannot rust, chip, absorb odors or peel. It is easily and quickly cleaned with hot water or steam and the rounded corners facilitate sanitation. The tray is light and strong, does not warp or rot and requires minimum maintenance. It is available in 14¼ by 25¼ inch size, 1⅛ inches deep. **Molded Fiberglass Tray Co., Linesville, Pa.**

For more details circle #538 on mailing card.

(Continued on page 224)

Room Deodorant Is Odorless

Fresh, clean air results with the use of Sterl-Air for deodorizing hospital rooms. It leaves no masking odor, is non-toxic, non-irritating and odorless. Unpleasant odors are eliminated and Sterl-Air is effective in combating airborne infections. A six second spray, directed toward the ceiling, freshens the air in a room ten feet square, according to the manufacturer. **S. M. Edison Chemical Co., 2710 S. Parkway, Chicago 16.**

For more details circle #539 on mailing card.

No Hands Required to Answer Telephone

The new Hands-Free Telephone developed by Stromberg-Carlson permits the busy administrator, technician or doctor to answer the telephone and carry on a conversation while continuing to work, or even while walking about the room. The new telephone has a microphone that is sensitive in all directions and can pick up conversation at ordinary voice levels from as far away as 20 feet. The user does not need to pick up the receiver and it is not even necessary to face the microphone for clear conversation. The microphone is lightweight and is attached to the telephone instrument by a 12 foot cord. It can thus be easily moved for most convenient placement and can be used for telephone conferences by placing it near the center of a participating group.

The automatic volume control in the microphone is compensated for irregularities in voice volume. The voice of the party at the other end of the line is amplified and heard through a loudspeaker built into the instrument. To initiate a call or to receive an incoming call the user simply presses the "On" button on the base of the instrument. A signal lamp lights, indicating that both the microphone and loudspeaker are alive. On completion of the call, pressing the "Off" button releases the line. When

privacy is desired the Hands-Free Telephone can be operated as a conventional telephone. The new telephone is compatible with any telephone system and gets its power from any standard outlet. **Stromberg-Carlson Co., 1225 Clifford Ave., Rochester 21, N.Y.**

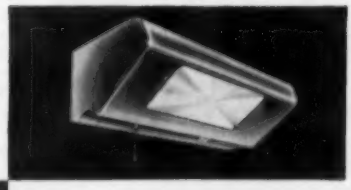
For more details circle #540 on mailing card.

Lighting by DAY-BRITE makes the big difference...

Cheerful lighting in modern hospitals

Day-Brite Troffers in corridors and nurses' stations.

Day-Brite Bed Lamps provide comfort and convenience for patients—direct light for reading; indirect light for general use.



Day-Brite Exit Signs mark exits, direct corridor traffic. Two sockets assure continuous operation if one lamp fails.

Day-Brite Duo-Frame Ceiling Unit and Nite Light.

Hospital administrators are more and more taking advantage of the cheerful effects of comfort lighting by Day-Brite. It benefits both patients and personnel.

Also, they are impressed by the economy of Day-Brite lighting. It can be counted on for 20 years and more of lighting service in reception halls, waiting rooms, bedrooms, corridors, nurses' stations, administrative offices.

When you specify lighting, insist on Day-Brite—be certain of lifetime service, low-cost maintenance and cheerful comfort... Call your Day-Brite representative—you'll find him in your classified phone directory. Or, send for hospital-lighting literature.

Day-Brite Lighting, Inc.
5455 Bulwer Ave.
St. Louis 7, Missouri

"DECIDEDLY BETTER"
DAY-BRITE
Lighting Fixtures

61109

Nation's largest manufacturer of commercial and industrial lighting equipment

Look at both sides of a bottle of 7-UP

On the *back* of the bottle, proudly listed for all to see, are the ingredients of this sparkling drink.

With good reason, 7-Up is famous as the All-Family Drink —so pure, so good, so wholesome for people of all ages.

The source of the 7-Up flavor is a fragrant, natural oil in the peel of lemons and limes. From every batch of this flavor source, Seven-Up selects less than 5%, *the very essence*, as being delicate and pure enough to be used in the "fresh up" drink!

Seven-Up is crystal-clear. No artificial flavor is used.

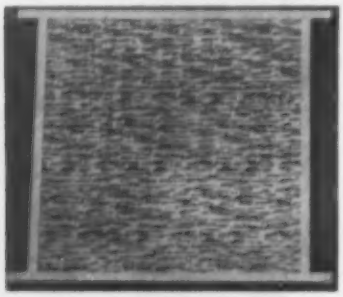
If you want a real thirst-quencher . . .
If you hanker for a cool, clean taste . . .
If you want a quick, refreshing lift . . .

Nothing does it like Seven-Up!

WHAT'S NEW

Sound Conditioner Combines Color and Economy

A new sound conditioning product that combines color, effective noise reduction, incombustibility, economy and easy



maintenance is introduced as Stria-Colored Steelacoustic. The white baked enamel steel panel has attractive overlay striations of black, green or brown to create a pleasing ceiling texture. Sound passes through the steel facing and into the absorbent material laminated behind it. Made of cold rolled zinc bond steel, the panels are two by two feet in size. They can be washed or painted with no effect on sound absorbency.

Stria-Colored Steelacoustic is installed on the Celotex "T and T" Suspension System, a suspended ceiling grid which is also finished in white baked enamel. Hold-down clips fasten the panels to the grids but permit easy access to the area above for servicing. Recessed light fixtures, air diffusers, sprinkler heads and other outlets can be incorporated into the ceiling plan. **The Celotex Corporation, 120 S. La Salle St., Chicago 3.**

For more details circle #541 on mailing card.

Vacuum Cleaner Has Transferrable Head

The new Hild hospital-quiet vacuum cleaner has a transferrable head that can be readily switched from one 55 gallon drum to another. It is also transferrable to the Hild 15 and 10 gallon size tanks.

It can thus be used for various cleaning jobs, performing the work of different sized vacuum cleaners. **Hild Floor Machine Co., Inc., 740 W. Washington Blvd., Chicago 6.**

For more details circle #542 on mailing card.

Decorative Micarta Unitop Combines Deck and Backsplash

The Unitop is a fully-formed one-piece sink or counter unit combining deck and backsplash. Introduced by United States Plywood Corporation and Westinghouse Electric Corporation, Unitop is constructed with Micarta, the Westinghouse plastic surface material, laminated and formed to ¼ inch Novoply, U. S. Plywood's all wood, three-ply panel made of wood chips and flakes, which is flat and stable. The durable plastic laminate runs from the top of the five inch backsplash through the cove and across the deck, up and over the front of the no-drip edge.

The Unitop is available in ten Micarta colors and patterns. It is packaged in lengths of 60, 72 and 96 inches. **United States Plywood Corp., 55 W. 44th St., New York 36.**

For more details circle #543 on mailing card.

Utility Kick Bucket of Stainless Steel

Stainless steel is used for the new Utility Kick Bucket which accommo-

dates a standard 13 quart pail. The unit is nine inches high. A non-marking rubber bumper completely encircles it to protect walls and furniture. Conductive rubber is used for caster wheels and rubber pail supports, and two inch ball bearing swivel casters assure stability and easy maneuverability. **The Colson Corporation, Elyria, Ohio.**

For more details circle #544 on mailing card.

Table Salt from Sea Water

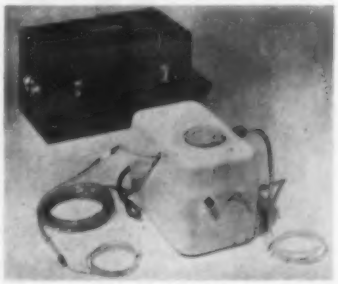
All of the presently known mineral elements, in essentially the same proportion that they exist in all ocean waters, are said to be contained in Trace Element Sea Salt. The result of a new process for making free-flowing table and cooking salt by evaporating sea water, the new food product is carefully processed for purity while preserving the natural mineral elements. It is a uniform, free-flowing salt for table and cooking use. **Trace Elements Corp., 718 N. Drennan St., Houston, Tex.**

For more details circle #545 on mailing card.

(Continued on page 228)

Tomac Pump Delivers Liquefied Whole Food

Liquefied whole food is delivered at a constant rate with the new Tomac Food Pump. The patient can sit up, lie down



or turn on either side without interrupting the constant rate of delivery. The pump operates with little or no supervision required. Material is forced through standard rubber tubing which is attached to a feeding tube. The rate of delivery is variable and the liquid does not touch the pump in any way, obviating the necessity for cleaning the pump internally. The pump is primarily designed to deliver liquefied natural foods and can also be used for administering juices, secretions, water, drugs and electrolytes. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #546 on mailing card.

Duplicator Work Base Is Versatile Cabinet

The new Trend Cabinet provides a sturdy work base for duplicating equipment. It also serves as a versatile storage cabinet for duplicating and other supplies. Designed by Jean Otis Reinecke, it has attractive modern lines and is finished in alcohol-resistant dark gray to prevent marring of the finish by duplicating fluids. Metal doors have gray walnut, wood grained finish and slide easily on nylon rollers. The Trend Cab-

inet is 30½ inches high with an adjustable shelf. The tapered wooden legs have adjustable brass feet which are self-leveling. **The Heyer Corporation, 1850 S. Kostner Ave., Chicago 23.**

For more details circle #547 on mailing card.

New St. Vincent's Infirmary cooks with modern *GAS* equipment

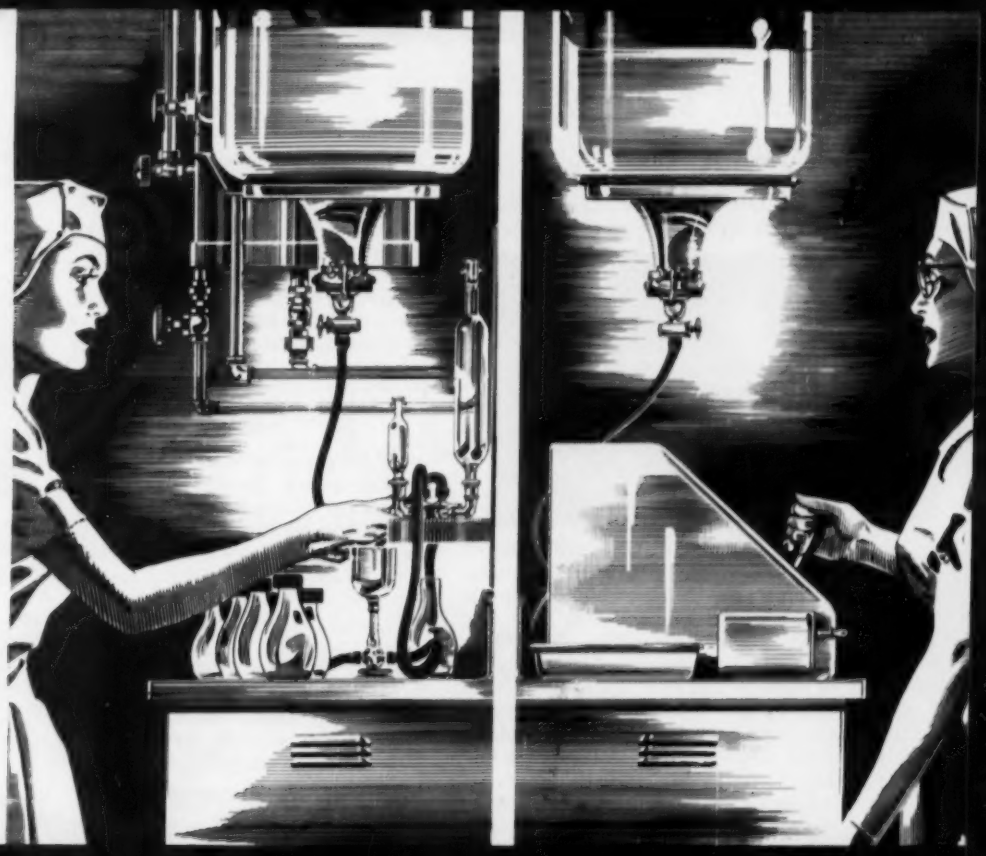
Hospital cooking calls for the best in kitchen equipment. That's why new hospitals, like St. Vincent's infirmary, Little Rock, Arkansas, choose Gas and modern Gas equipment.

Gas gives flexibility and control for specific diet requirements. Gas is clean and dependable with no interruption in service. Gas also brings out the goodness and appetizing appearance of food to make it appeal to the patient.

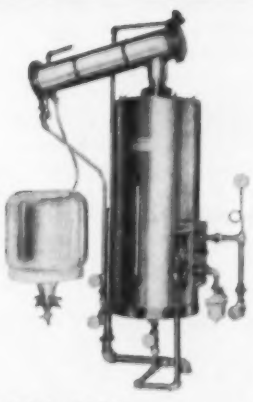
Gas equipment at St. Vincent's includes Garland ranges, Fish reel-type bake ovens, Blodgett bake ovens, Steam-Chef steamers and Savory toasters. Gas also provides St. Vincent's with hot water.

For information on how you can benefit by installing modern Gas equipment, call your Gas Company commercial specialist. He'll be glad to discuss the economies and results Gas and modern Gas equipment provide. *American Gas Association.*

Barnstead Pyrogen-Free Distilled Water at Work:



. . . in the Central Supply



BARNSTEAD "15"

Designed expressly for hospital use, this NEW Still supplies 15 g.h.p. It often replaces two older, small stills, saving time, space, and money for you. Purity features include: vented condenser to expel gaseous impurities, famous Spanish-prison baffle, constant-level control, demountable condenser for fast, easy cleaning, low-velocity evaporator, easy-clean heating coil, constant bleeder device. *Costs little more* than ordinary 10 g.h.p. stills!

MORE THAN 60,000 BARNSTEAD INSTALLATIONS NOW IN USE

AT THIS MOMENT, in hospitals all over the world, Barnstead Stills are producing *abundant Pure Water* for every medical need. In hundreds of Central Supplies, dependable, modern Barnstead equipment is meeting the ever-increasing demand for pyrogen-free distilled water of utmost purity. In thousands of ORs, Blood Banks, and Pharmacies, Barnstead Pure Water is now *at work*.

Put this *reliable* source of distilled water to work in *your* hospital. Reap the benefits of truly modern distillation — moderate first cost, minimal operating cost, negligible maintenance — enjoyed by hundreds of leading hospitals that *rely on Barnstead* for *all* Pure Water needs.

Write for special hospital literature.

Barnstead STILL & STERILIZER CO.

31 Lanesville Terrace
Forest Hills
Boston 31, Mass.

First in Pure Water Since 1878

WHAT'S NEW

Flexible Arm Lamp Has "Kold" Shade

The new Faries adjustable incandescent lamp for close work features the

new "Kold" shade. Users are protected from burns since even after continuous burning of a 100 watt bulb, the outside shade is cold to the touch. The flue effect of the shade draws off the heat with a fast up-current. A new method of radiation and reflection also eliminates heat in the "Kold" lamps. The Faries new universal "Friction Free" adjustment employs the gravity principle giving virtually unlimited frictionless adjustments. The new lamp arms extend from 12 to 38 inches and lamps are available in a total of eight types in both fluorescent and incandescent. **Faries Lamp Division, General Lamps Mfg. Corp., Elwood, Ind.**

For more details circle #548 on mailing card.

Slant-Back Drop Edge in Plastic Tops

The new Type FF Johnson Plastic Top is now available in the 2 inch Slant-Back drop edge. The super-bonded deluxe edging combines extreme durability with attractive, modern appearance for table and counter tops. It features the Johnson construction of nine plies of uniform, sound hardwood with plies, plastic sheet and plastic backing superbonded with a special adhesive. **Johnson Plastic Tops, Inc., Elgin, Ill.**

For more details circle #549 on mailing card.

Lacta Breast Pads Absorb Excess Lacation

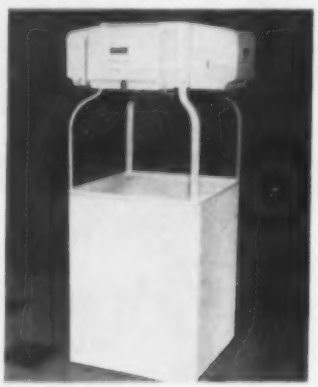
Anatomically shaped breast pads are offered with soft, non-irritating absorbent cotton liners and non-absorbent facing. A fully sealed circumference rim prevents seepage. The improved Lacta Breast Pads are designed for maximum comfort and freedom from pressure. They are made in an adequate size for assured absorption and retention, thus giving full protection. The pads are disposable and are excellent for use with medications. **The Seamless Rubber Co., New Haven 3, Conn.**

For more details circle #550 on mailing card.

Towel Dispensing Unit Has Receptacle Stand

The new Mosinee Four-Way Dispensing Stand has an unusually large receptacle unit for used towels. The easily removable canvas bag facilitates maintenance and the receptacle and bag are large enough to handle washroom needs without litter.

The new stand can accommodate from one to four Mosinee towel cabinets, of any type, depending on the number needed to give adequate service in the washroom. It is ruggedly constructed



and heavily built to remain firm during use. The commodious unit can be adapted to handle requirements of any sized washroom. It reduces time required for maintenance and improves washroom appearance. **The Bay West Paper Co., Green Bay, Wis.**

For more details circle #551 on mailing card.

Sterilizing Case for Lumbar and Venous Technics

Developed by Boston City Hospital Central Supply, the Ranfac Sterilizing Case is designed to facilitate the assembly, autoclaving and storage of the accessories for lumbar puncture and venous pressure technics. It is made of stainless steel with a full length hinged snap-lock cover and removable tray. Components of the outfit are held firmly by spring clips. Perforations are arranged for steam penetration of the entire interior for complete sterilization. The case is available separately or complete with instruments. **Randall Faichney Corp., 299 Marginal St., Boston 28, Mass.**

For more details circle #552 on mailing card.

(Continued on page 232)

Mattress Cover Protects Top and Sides

The new Continental Mattress Protector provides complete protection for the top and all sides of the mattress. It is

made of Elasticon, fabricated from Plasticon hospital sheeting which can be boiled and autoclaved and is non-combustible. It is firmly held in place by reenforced elastic bands which pass under the mattress across each corner for patient comfort and neat appearance. **Continental Hospital Service, Inc., 18624 Detroit Ave., Cleveland 7, Ohio.**

For more details circle #553 on mailing card.

Mobile Commode Is Bed Height

The new Komfort Bed-High Commode is designed to eliminate the need for ped pans for patients able to move around in bed. The lightweight, all aluminum construction makes the commode highly mobile. It is firmly attached to the bed in a matter of seconds with a mated bracket that fits any hospital bed. The patient is thus able to position himself on the commode with little or no assistance and with no uncertainty since the commode is stable. It is as easily detached when no longer required.

A foot rest on the Bed-High Commode adds to the patient's comfort, as do back and arm rests. These also add to the sense of security in using the commode. The container is molded to fit the seat perfectly and is placed into the seat from above. It is easily cleaned and has a friction fitted lid for ease of handling

and improved sanitation. **Will-Mark Company, P. O. Box 4098, Valley Village, North Hollywood, Calif.**

For more details circle #554 on mailing card.

cut

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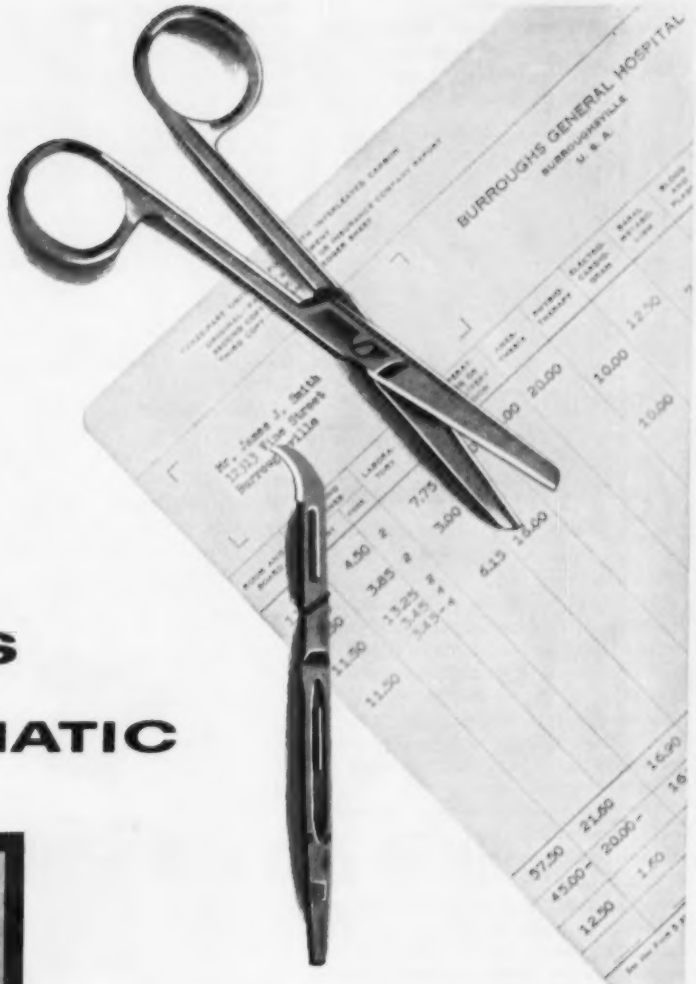
BURROUGHS SENSIMATIC



For simplified patient accounting and preparation of Blue Cross reports, you'll find the ideal answer in Burroughs Sensimatic combined with the columnar method of distribution of charges.

With this accounting plan, all charges are automatically indicated under the proper heading on the statement. Then, at the end of the accounting period, totals can be obtained by simply turning a knob and pressing the motor bar. A duplicate copy meets all requirements of Blue Cross. Reimbursement from both Blue Cross and the patient are greatly simplified.

Thanks to the exclusive sensing panel, Sensimatic will handle other jobs by a simple turn of the job selector knob. For a demonstration call our nearest branch office, listed in your telephone directory. Burroughs Corporation, Detroit 32, Michigan.

WHEREVER THERE'S BUSINESS THERE'S

"BURROUGHS" AND "SENSIMATIC" ARE TRADE-MARKS

WHAT'S NEW

Paper Electrophoresis With Continuous-Flow Apparatus

The new Spinco Continuous-Flow Paper Electrophoresis Apparatus permits improvements in terms of flexibility and

efficiency. New methods of electrolyte feed and wide-range controls in the instrument permit maximum throughput under any required degree of resolution. Resolutions are also made at lower values because of the increased design efficiency. The new unit is applicable to the separation of all kinds of charged substances and handles such organic substances as dyes and intermediates. It is also useful for following organic reactions and for immuno-chemical work.

The new apparatus is easily assembled and disassembled for cleaning, paper curtains are quickly removable for oven drying in analytical applications, a wide range of types and thicknesses of curtains can be used, and it has a specially-designed pump which circulates or recirculates the buffer. **Spinco Division, Beckman Instruments, Inc., 673 O'Neill Ave., Belmont, Calif.**

For more details circle #555 on mailing card.

Forced Air Ozonator Preserves Foods

Necessary concentrations of ozone for air deodorization and the preservation of meats and foods in storage are achieved with the new Air-03-Fresh Eagle Ozonator. The compact unit inhibits the growth of mold, mildew and bacteria on foods and cooler walls, retards ripening of vegetables, inhibits sprouting, maintains fresh-air atmosphere and prevents tainting and transfer of food odors.

New engineering features of the Eagle include forced air circulation with special filtering and heating element for use where high humidity would otherwise interfere with efficient ozone production. The special filtering and heating system draws air through a glass fiber filter and passes it over a heating plate to reduce the moisture content. The air then passes over four generating grids which form the oxidizing gas. **Melco Sales, Inc., 305 Fifth Ave. S., Minneapolis 15, Minn.**

For more details circle #556 on mailing card.

Improved Feed Doors on Incinerators

Two new feed doors are available on Winnen Incinerators. The Guillotine door is a single sheet of heavy gauge steel with a refractory lining which slides up to open. The new double feed doors open in the conventional manner. Both types are counterbalanced for easy operation and are oversized to receive entire crates and boxes. **Winnen Incinerator Co., 932 Broadway, Bedford 32, Ohio.**

For more details circle #557 on mailing card.

Telephone System for Internal Communication

The new Kellogg Push-Button Intercommunications 6-PB System is designed for institutions with limited requirements. It provides a low cost, efficient telephone system for direct contact at the press of a button. It allows direct connections among all telephones in the system and individual ringing for each station. Conference facilities are also provided, permitting "round table meet-

ings" between all stations without anyone leaving his desk.

No switchboard equipment is required since the Kellogg 6-PB is an "inside" telephone system. It is completely independent of the city telephone system, is low in cost, simple to install and is built to provide years of trouble-free service with a minimum of maintenance. A choice of desk or wall telephone instruments is available, as well as an optional system including voice signal paging. **Kellogg Switchboard & Supply Co., 79 W. Monroe St., Chicago 3.**

For more details circle #558 on mailing card.

Shower Mixing Valve Is Concealed

The new Type BCA individual concealed thermostatic shower mixing valve is concealed by one dial plate. Internal valve parts are of stainless steel with polished chrome finish on all exposed parts. Valve, stops, checks and strainers are readily accessible for service when desired. **Lawler Automatic Controls, Inc., 453 N. MacQuesten Pkwy., Mt. Vernon, N. Y.**

For more details circle #559 on mailing card.

(Continued on page 234)

Laboratory Slips Have Adhesive Back

Press-on gumming is now used on Snap-Out Lab Slips. Forms are available in duplicate or triplicate, as required. The special pressure-sensitive adhesive on the back permits recording data, snapping out copies and when the protective covering is peeled from the back of the original copy, the slip is pressed on the master report without waiting or use of water. The slips are three by five inches in size and are available in 18 different types. **Physicians' Record Co., 161 W. Harrison St., Chicago 5.**

For more details circle #560 on mailing card.

Warning Signal for Temperature Fluctuation

An immediate audible or visual warning signal is available in the YSIC Thermal Alarm for use in any situation requiring automatic detection and warning of increasing or decreasing body temperatures. It can be incorporated into existing private room or ward systems which operate lights or buzzers at a central nursing station if desired. Originally designed for signaling the onset of post-operative hyperthermia in the recovery room, the unit is effective in any situation where it is necessary to watch rectal temperature fluctuations.

The unit is compact and inexpensive. It employs a temperature-sensing thermistor in an unbreakable rectal probe at the end of a rugged yet flexible vinyl-insulated lead wire. The illuminated dial sets any desired alarm temperature between 85 and 110 degrees F. A quick accurate reading of the patient's rectal temperature can be made by merely rotating the dial until the alarm operates and noting the temperature reading at that point. Use of the unit reduces nursing time and breakage hazard connected with taking post-operative temperatures and in addition provides an automatic alarm if temperatures reach the danger point. The self-contained buzzer and light normally signal when the pre-set maximum temperature is reached but

will function at a selected minimum temperature if desired. The unit is easily transported by the convenient carrying handle. **Yellow Springs Instrument Co., P. O. Box 106, Yellow Springs, Ohio.**

For more details circle #561 on mailing card.

Hospital Vac Cuts Cleaning Time at Miller

Modern, 360-bed Miller Hospital in St. Paul, Minnesota, has further reduced cleaning time with the recent purchase of a wet-dry Hospital Vacuum Cleaner.

With its unusually quiet operation and gleaming hospital-whiteness, the new MULTI-CLEAN vac teams up with a MULTI-CLEAN Scrubbing Machine and two floor machines already in service at this modern hospital.

Miller Mechanizes

Mechanized floor care is taken for granted at Miller. The floor machines are used to scrub, polish, wax, buff, and steel wool the floors. The new vac cleans floors, rugs and carpets, picks up scrub water, and comes in handy on dozens of other cleaning jobs from floor to ceiling.

Appearance is Important

Like thousands of other hospitals from coast to coast, Miller is proud of the appearance of their 205,000 square feet of floor area. Corridors are rubber tile; patients' rooms, X-Ray room and lab are asphalt tile; surgery and sub-basement floors are terrazzo.

All floors are mopped daily and machine-polished as often as necessary to keep them bright and attractive. Twice a year they are re-waxed.

Sanitation and Appearance...with less work

With its program of scientific, mechanized floor care, Miller Hospital has been able to substantially reduce cleaning time and at the same time, maintain highest standards of sanitation and appearance.

Mechanized floor care can also bring important savings to your hospital. For more information on the famous MULTI-CLEAN METHOD of floor care and how much it will enable *you* to save, ask your MULTI-CLEAN Distributor for a demonstration and free floor survey . . . or mail the coupon below.

WHAT'S NEW

Spray Type Dishwasher Removes Lipstick Stains

A new line of spray type dishwashers recently introduced is said to remove lipstick stains from glasses and cups

without the use of brushes. The new improved wash nozzles, extra driver nozzles and a wash spray system operating above and below the glasses produce an unusually effective spray pattern which penetrates the entire rack area, reaching up into all glasses in the machine. When used with wash water at 150 degrees and proper concentration of the new glass washing compounds, all kinds of soil, including lipstick and grease stains, can be completely removed.

Two sizes are available in the new machines. Model WG can be installed under or on a counter and requires only 20 by 20 inches of space. A minimum amount of additional drain table space is required. The machine holds 30 average sized water glasses. Model DG is designed for volume glass washing, handling approximately 2700 average sized water glasses per hour. **Universal Dishwashing Machinery Co., 37 Windsor Place, Nutley 10, N.J.**

For more details circle #562 on mailing card.

Orange Cake Quickly Made With Mix

Orange Cake can now be made without fuss or bother. Pillsbury's Orange Cake Mix contains tiny tidbits of fresh, tree-ripened fruit. It is only necessary to add water and bake to produce a light textured cake with natural fruit flavor. Each 6/5 case will produce 48 eight inch layers, 456 one and one-half ounce cup-cakes or 540 two by three inch cuts of sheet cake. **Pillsbury Mills, Inc., Minneapolis 2, Minn.**

For more details circle #563 on mailing card.

Vinyl-Clad Door in Seven Colors

A decorative as well as functional door is now available in Kawneer Vinyl-Clad Flush Doors. Laminated to an aluminum backing sheet, the vinyl is abrasion and mar resistant, providing a highly decorative yet sturdy door. The laminate is impervious to spilled liquids and is easily cleaned with soap and water. Available in seven colors, the vinyl is also offered in a variety of finishes.

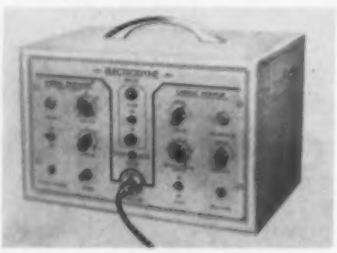
The door has sandwich construction with a honeycomb core to give it light weight with rigidity. The door is highly moisture-resistant with aluminum faces double lapped at the top edge and sealed with mastic. Available with a wide variety of glazed or louvered panels, the door is also available with anodized aluminum skin as well as the vinyl-clad skin. **Kawneer Company, Niles, Mich.**

For more details circle #564 on mailing card.

Electrodyne PM-65 Treats Cardiac Arrest

Cardiac arrest is instantly indicated, and effective external stimulation to the dormant heart is started automatically with the new Electrodyne PM-65. Three flat disc electrodes are applied to the patient and held in place by a rubber chest strap. They are permanently attached to the 12 foot molded patient cable.

The monitor section of the instrument is activated by the QRS complex which



represents the ventricular contraction or heart beat. Each heart beat is indicated by a neon flash and an audible note. If the heart should either stop or slow below a predetermined rate, as set by the operator, an alarm sounds. The Cardiac Pacemaker section automatically sends electric stimuli to the patient's heart. Either the Cardiac Pacemaker section or the monitor section may be operated independently if desired. **Electrodyne Co., Inc., Norwood 5, Mass.**

For more details circle #565 on mailing card.

Tropical Cement Bond for Cracked Concrete

A new liquid product is offered for patching broken or cracked concrete floors, steps and driveways. Brushed on the old concrete surface to bond the new patch to it, Tropical Cement Bond is clean and simple to use. Patches hold indefinitely, even under heavy traffic conditions. The new cement bond can be used successfully for patching or to lay a new floor over an old one, according to reports. **Tropical Paint Co., 1246 W. 70th St., Cleveland 2, Ohio.**

For more details circle #566 on mailing card.

(Continued on page 236)

Maintenance Ladder Has Adjustable Rungs

Safety and convenience are features of the improved Painter's Step Ladder. Back rungs are alternately spaced with steps allowing workmen to adjust working height every six inches. All front steps have steel tie rods and a strong, horseshoe type hinge, and steel rung braces are placed on pack rungs. **The Patent Scaffolding Co., Inc., 38-21 12th St., Long Island City 1, N.Y.**

For more details circle #567 on mailing card.

"Handy-Andy" Kit Holds All-Purpose Screws

The correct screw for any job is at your finger tips with the "Handy-Andy" kit. The new kit contains an assortment of the 21 most popular sizes of all-purpose, self-tapping screws in a two gross assortment properly proportioned according to the sizes most frequently used. **J. A. Sexauer Mfg. Co., Inc., 2503 Third Ave., New York 51.**

For more details circle #568 on mailing card.

Steam Cookers in Two Models

A two-compartment steam cooker with a lower, more compact cabinet base, is available in an electric and a gas model. Cooking compartments are placed at a more efficient working height in the new models which are also available with compartments in two depths. Standard compartments hold standard steam cooker pans and will cook up to four bushels of food. Cafeteria-type compartments hold as many as four 12 by 20 by 2¼ inch and two 12 by 20 by 4 inch pans in each compartment. Model 2M-E for electric and Model 2M-G for gas operation are complete with all necessary controls for fast, safe, efficient cooking.

The new models occupy less than eight square feet of floor space. They are available in standard finishes, either stainless steel interior with enamel ex-

terior and base, or stainless steel interior with polished stainless steel exterior and base. **Market Forge Co., Everett 49, Mass.**

For more details circle #569 on mailing card.

WHAT'S NEW

Floor Machine Lock Facilitates Stair Climbing

Easy transport up and down stairs of the new Advance Pacemaker Floor Machine is made possible by the "Retractolock" feature. The wheels are raised by

a spring-actuated lever and lowered with an easy foot movement. When locked in the up position, the machine is easily transported up and down stairs with minimum effort.

Designed for heavy duty polishing, waxing, scrubbing, steel wooling and shampooing, the machine has a low front housing to permit working under recessed baseboards, beds and other furniture and equipment. The "Silent Flo" drive is another Advance feature which drives the brush through a silent, positive, greaseless transmission. The handle of the new Pacemaker is fully adjustable for use and storage and the machine is equipped with a dual control safety switch. **Advance Floor Machine Co., 2613 4th St. S. E., Minneapolis 14, Minn.**

For more details circle #570 on mailing card.

Simoniz Maintenance Products for Institutional Use

The line of Simoniz maintenance products has recently been made available for commercial and institutional maintenance. Included are Simoniz Heavy Duty Floor Wax, Simoniz All Purpose Floor Cleaner, Simoniz Non-Scuff Floor Wax, Simoniz HiLite Furniture Polish and Simoniz Triple "A" Paste Floor Wax. The first three products are available in 1, 5, 30 and 55 gallon sizes. Furniture polish is supplied in light and dark for the desired finish, in quart bottles. The paste floor wax is contained in five pound triple tight closure cans. **Simoniz Company, Commercial Products Division, 2100 Indiana Ave., Chicago 16.**

For more details circle #571 on mailing card.

Hot Water Bottle Has Dual Heat Surfaces

A new hot water bottle has been developed with one side cooler than the other. The "Warm-N-Hot" bottle has tiny, raised rubber ribs forming the surface of the cool, air conditioned side. Cooling air circulates so that this side of the bottle can be placed against the patient even when the water is too hot for comfort. When the temperature of the water drops, the bottle may be reversed so that the unribbed, flat surface comes in contact with the patient at the proper temperature for comfort. The new bottle can be filled with water hotter than would ordinarily be comfortable, and requires less frequent re-filling. **The B. F. Goodrich Co., Akron, Ohio.**

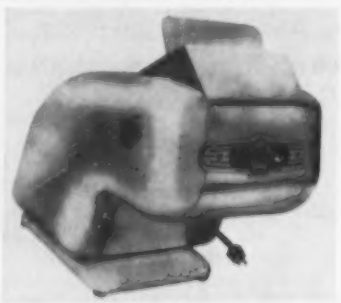
For more details circle #572 on mailing card.

Convector Radiation Line Completely Redesigned

A line of convector radiation manufactured by Modine has been completely redesigned to give greater freedom in adapting convectors to modern building design. Free-standing, fully and partially recessed, concealed (plaster-front) and wall-hung models are included in the new line. Most of these types are offered in standard gauge enclosures as well as in heavy-gauge enclosures for heavy duty institutional applications. Convector heating units for the new line have also been redesigned to simplify installation and provide silent, high capacity performance. Thirty different types and over 8000 sizes are offered in the redesigned line. **Modine Manufacturing Co., Racine, Wis.**

For more details circle #573 on mailing card.

Meat Tenderizer Offers Maximum Safety



Model-LB SirSteak Tenderizer has been designed to meet rigid safety requirements. The safety chute guides fingers away from blades, no matter how small the hand may be. The safety switch does not permit the machine to operate except when the hopper is closed. Accidental injection of fingers from beneath is prevented by the safety design.

All standard features of the SirSteak machine are included in the new model. All parts contacting meat are of stainless steel. The machine is especially designed for efficient operation and it is easily cleaned. It gives an inter-weaving action for more tender meat. **SirSteak Machinery, Inc., P.O. Box 201, Concord, Mass.**

For more details circle #574 on mailing card.

(Continued on page 238)

Pharmaceuticals

Quadrates

Quadrates (Concentrated Electrolyte Additive Solutions) are offered in a choice of four electrolyte concentrates in 30 cc. vials: Sodium Chloride, Sodium Lactate, Ammonium Chloride and Potassium Acetate. Each Quadrate has a four molar concentration and each cc. of additive contains 4 mEq. of that electrolyte. They are designed to permit making of any desired combinations of electrolyte solutions. **Cutter Laboratories, Berkeley 10, Calif.**

For more details circle #575 on mailing card.

Sigmagen

Sigmagen is a new corticoid-analgesic preparation combining the anti-inflammatory and anti-rheumatic cortico-steroid prednisone with aspirin, vitamin C and antacid aluminum hydroxide. It is indicated in the treatment of rheumatic-arthritic disorders. Clinical studies have indicated that in some cases the concomitant administration of corticoids and salicylates permits a lower dosage of each to achieve an equal or better degree of therapeutic effect. Sigmagen is supplied in tablet form in bottles of 100 and 1000. **Schering Corporation, Bloomfield, N. J.**

For more details circle #576 on mailing card.

Hydeltra Tablets

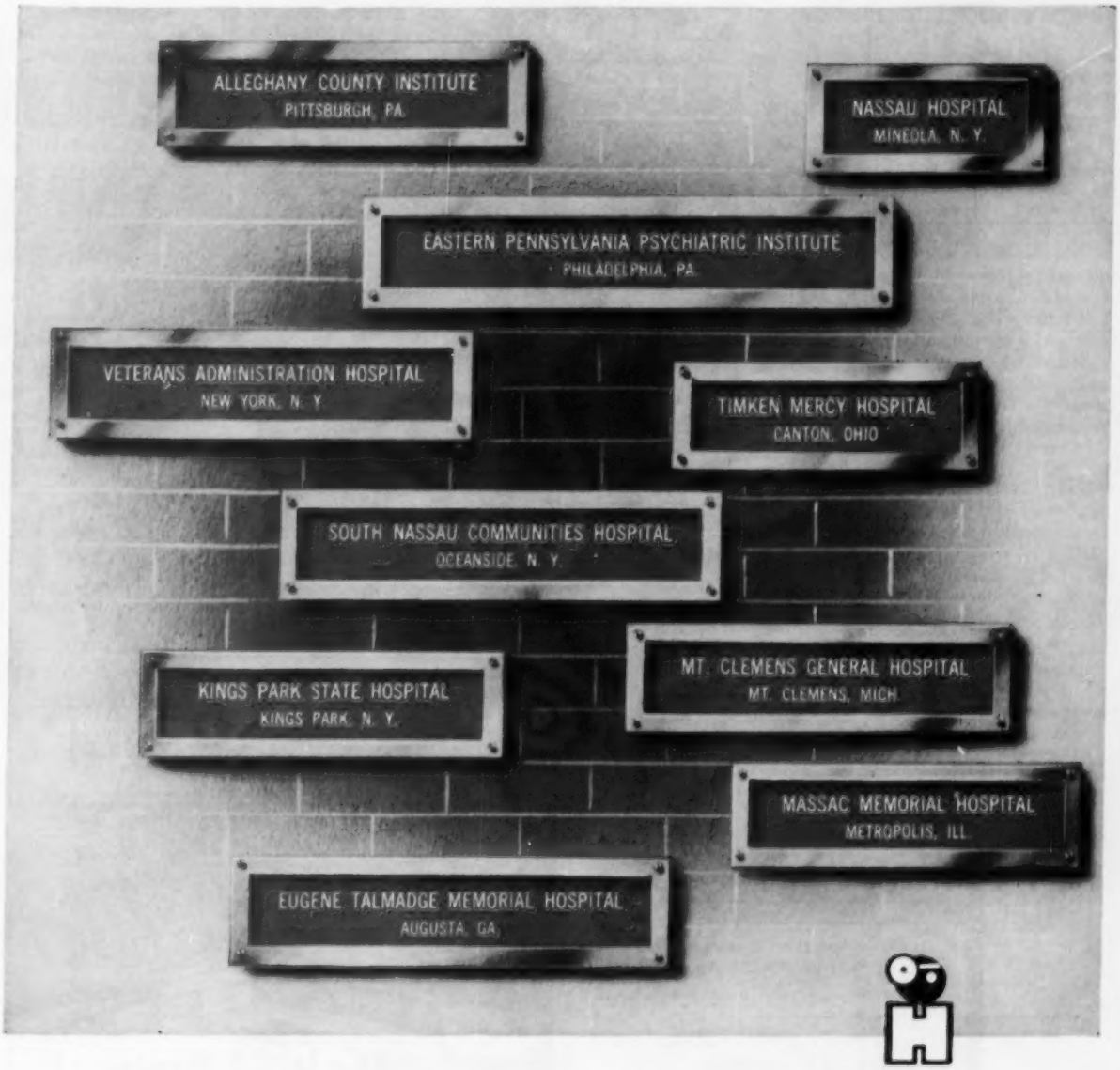
Hydeltra Tablets are a new product with more potent anti-inflammatory action than either cortisone or hydrocortisone, according to the announcement. A synthetic analogue known generically as prednisolone, Hydeltra has been added to the extensive line of Merck adrenocortical steroids. Clinical data indicates that it is approximately three to five times as active on a weight basis as hydrocortisone or cortisone. Usual therapeutic doses, according to reports, rarely cause salt or water retention. Hydeltra Tablets are supplied in bottles of 30 and 100. **Sharp & Dohme, Div. of Merck & Co., Inc., 640 N. Broad St., Philadelphia 1, Pa.**

For more details circle #577 on mailing card.

Diafen

Diafen is a new antihistaminic product with low incidence of side effects. It is indicated in the treatment of a wide variety of allergic manifestations and disorders. It is also valuable in the management of penicillin reactions and related drug sensitivities. Diafen is readily absorbed from the gastrointestinal tract and provides prolonged relief on low dosage. It is supplied in 2 mg tablets in bottles of 100 and 1000. **Schenley Laboratories, Inc., 350 Fifth Ave., New York 1.**

For more details circle #578 on mailing card.



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High capacity in small space—low linen laundry cost per patient day—and top production per operator per hour, these vital advantages are built into the new laundries designed and equipped by U.S. Hoffman for the hospitals listed here.

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U.S. HOFFMAN MACHINERY CORP.

105 FOURTH AVENUE, NEW YORK 3, N. Y.

WHAT'S NEW

Product Literature

• A new **Oxygen Therapy Apparatus and Accessories Catalog** is now available from the Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis. The new Model 25 oxygen tent is discussed in the 20 page catalog. It also illustrates and describes the company's re-usable and disposable oxygen tent hood, Airco two-stage pressure regulators, B-L-B and single-stage regulators, the aerosol nebulizer, humidifier, oxygen therapy masks, bedside emergency oxygen units, portable emergency oxygen and resuscitation unit, cylinder trucks, post-operative oxygen units and the complete line of oxygen therapy accessories. The catalog is indexed and is available as Form 2180-OT.

For more details circle #579 on mailing card.

• How **Aeroplast Liquid Surgical Dressing** can be used to protect the skin around incisions and treatment areas, as well as serving as a liquid dressing, is discussed in an eight page booklet released by Aeroplast Corporation, 420 Dellrose Ave., Dayton 3, Ohio. How this tough, flexible, transparent dressing is applied and its various uses, as well as a discussion of toxicity and sensitivity and the experimental studies made, are subjects of interest in the booklet.

For more details circle #580 on mailing card.

• **The methods of processing surgical silk** and how processing influences the qualities of the silk in use are described in a new booklet released by Ethicon, Inc., New Brunswick, N. J. The three important physical properties for silk suture material are given as non-capillarity, tensile strength and handling qualities. How Ethicon processing retains these qualities even after repeated autoclaving is pointed out in the booklet.

For more details circle #581 on mailing card.

• Technical data and specifications for installation of **"Fiberglas Reinforced Built-Up Roofs"** is available in a new 32 page booklet released by Owens-Corning Fiberglas Corp., Toledo 1, Ohio. Detailed descriptive information is given in the booklet on the various application techniques for Fiberglas Perma-Ply No. 6, a porous mat of strong glass fibers used to reinforce bitumen on roofs.

For more details circle #582 on mailing card.

• Full information on the completely redesigned line of **Airtemp Commercial Water-Cooled Packaged Air Conditioners** is available in an eight page booklet recently released. Designated as **Booklet L-241,** the publication gives unit specifications and data on uses and operating costs. It is available from The Airtemp Division, Chrysler Corp., P. O. Box 1037, Dayton 1, Ohio.

For more details circle #583 on mailing card.

• A series of **instruction cards on the use of Amphyl(R) brand disinfectant** is available from Lehn and Fink Products Corp., Professional Division, 445 Park Ave., New York 22. Designed for use on bulletin boards and in training classes for nurses and other personnel, each card gives simple instructions on a particular type of application of Amphyl. The first two cards of the series are now ready for distribution. "General Disinfection," the subject of the first card, outlines the easiest method for applying Amphyl for disinfection of floors, walls, furniture and washrooms. Methods for "Tuberculosis Hygiene" of the patient area during hospitalization and of the premises at discharge are presented in the second card.

For more details circle #584 on mailing card.

• The entire line of **Cres-Cor Infra-Red Food Warmers** is discussed and illustrated in a new three color catalog published by Crescent Metal Products, Inc., 18901 St. Clair Ave. N.E., Cleveland 10, Ohio. New models of the units as well as standard models are shown with information on the use of these food warmers which keep food hot without drying it out. Three basic types of radiant energy are employed in the warmers and a variety of hood designs in attractive anodized satin gold or aluminum finish is available.

For more details circle #585 on mailing card.

(Continued on page 240)

PRODUCT INFORMATION

Index to "What's New"

Pages 219-240

Key
530 Barbamotto
Westinghouse Electric Corp.

531 Surgical Cosmetic Soap
American Safety Razor Corp.

532 Cinefluorography Apparatus
General Electric Co.

533 Meals for Vending Machines
H. J. Heinz Co.

534 Operating Light with Camera
Wilmot Castle Co.

535 Individual Frozen Packets
M & R Dietetic Laboratories, Inc.

536 Vending Machine for Milk
Norris Dispensers, Inc.

537 "Redi-Serv" Trayoart
Mealpack Corp.

538 Toteline Tray
Molded Fiberglass Tray Co.

539 Steri-Air
S. M. Stinson Chemical Co.

540 Hands-Free Telephone
Stromberg-Carlson Co.

541 Strip-Colored Steelacoustic
The Celotex Corp.

542 Vacuum Cleaner
Mid Floor Machine Co., Inc.

543 Unitop
U. S. Plywood Corp.

544 Utility Kick Bucket
The Colson Corp.

545 Hex Bolt
Truss Elements Corp.

546 Food Pump
American Hospital Supply Corp.

547 Trend Cabinet
The Hoyer Corp.

548 "Knit" Shade Lamp
General Lamps Mfg. Corp.

549 Type VT Plastic Top
Johnson Plastic Tops, Inc.

550 Lacta Breast Pad
The Seamless Rubber Co.

551 Four-Way Dispensing Stand
Bay West Paper Co.

Key
552 Sterilizing Case
Randall Faichney Corp.

553 Mattress Cover
Continental Hospital Service, Inc.

554 Bed-Rich Commode
Will-Mark Co.

555 Electrophoresis Apparatus
Spinco Div.

556 Cannister
Melco Sales, Inc.

557 Improved Feed Doors
Wilmen Incinerator Co.

558 Push-Button Intercom System
Kellogg Switchboard & Supply Co.

559 Shower Mixing Valve
Lawler Automatic Controls, Inc.

560 Snap-Out Lab Slips
Physicians' Record Co.

561 Thermal Alarm
Yellow Springs Instrument Co., Inc.

562 Spray Type Dishwasher
Universal Dishwashing Machinery Co.

563 Orange Cake Mix
Pillsbury Mills, Inc.

564 Vinyl-Clad Doors
Kawneer Co.

565 Electrodyne PM-65
Electrodyne Co.

566 Cement Bond
Tropical Paint Co.

567 Improved Step Ladder
The Patent Scaffolding Co., Inc.

568 "Handy-Andy" Kit
J. A. Sexauer Mfg. Co., Inc.

569 Steam Cookers
Market Forge Co.

570 Floor Machine
Advance Floor Machine Co.

571 Simonix Commercial Line
Simonix Co.

572 Dual Heat Hot Water Bottle
B. F. Goodrich Co.

Key
573 Convector Radiation
Modine Mfg. Co.

574 SirSteak Tenderizer
SirSteak Machinery Co.

575 Quadratee
Cutter Laboratories

576 Sigmagen
Schering Corp.

577 Hydeltra Tablets
Sharp & Dohme

578 Diales
Schenley Laboratories, In

579 Catalog
Ohio Chemical & Surgical Co.

580 Booklet
Aeroplast Corp.

581 Booklet
Ethicon, Inc.

582 "Fiberglas Built-Up Roofs"
Owens-Corning Fiberglas

583 Booklet
Airtemp Div.

584 First Insruction Cards
Lehn and Fink Products Co

585 Cooling
Crescent Metal Products,

586 Manual on Door Controls
Dor-O-Matic Div.

587 Bulletin 690A
Precision Scientific Co.

588 "Rx Recreation"
National Recreation Assoc

589 "Blueprint for Tomorrow"
U. S. Gypsum Co.

590 Folder on Patient Elevator
Lowry Mfg. Co.

591 Bulletin E. L. 16
Surrette Storage Battery C

592 Hospital Product Guide
J. A. Delmatel & Son, Inc.

593 Catalog No. 955
Georgres Wringer, Inc.

Index to Products Advertised

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—33rd Edition

INDEX CONTINUED ON FOLLOWING PAGE

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February, 1956

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

WHAT'S NEW

530	531	532	533	534
535	536	537	538	539
540	541	542	543	544
545	546	547	548	549
550	551	552	553	554
555	556	557	558	559
560	561	562	563	564
565	566	567	568	569
570	571	572	573	574
575	576	577	578	579
580	581	582	583	584
585	586	587	588	589
590	591	592	593	

ADVERTISEMENTS

594	595	596	597	598	599	600	601	602	603	604	605	606	607	608
609	610	611	612	613	614	615	616	617	618	619	620	621	622	623
624	625	626	627	628	629	630	631	632	633	634	635	636	637	638
639	640	641	642	643	644	645	646	647	648	649	650	651	652	653
654	655	656	657	658	659	660	661	662	663	664	665	666	667	668
669	670	671	672	673	674	675	676	677	678	679	680	681	682	683
684	685	686	687	688	689	690	691	692	693	694	695	696	697	698
699	700	701	702	703	704	705	706	707	708	709	710	711	712	713
714	715	716	717	718	719	720	721	722	723	724	725	726	727	728
729	730	731	732	733	734	735	736	737	738	739	740	741	742	743
744	745	746	747	748	749	750	751	752	753	754	755	756	757	758
759	760	761	762	763	764	765	766	767	768	769	770	771	772	773
774	775	776	777	778	779	780	781	782	783	784	785	786	787	788
789	790	791	792	793	794	795	796	797	798	799	800	801	802	803
804	805	806	807	808										

NAME _____ TITLE _____

INSTITUTION _____

ADDRESS _____ CITY _____ ZONE _____ STATE _____

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WHAT'S NEW

530	531	532	533	534
535	536	537	538	539
540	541	542	543	544
545	546	547	548	549
550	551	552	553	554
555	556	557	558	559
560	561	562	563	564
565	566	567	568	569
570	571	572	573	574
575	576	577	578	579
580	581	582	583	584
585	586	587	588	589
590	591	592	593	

ADVERTISEMENTS

594	595	596	597	598	599	600	601	602	603	604	605	606	607	608
609	610	611	612	613	614	615	616	617	618	619	620	621	622	623
624	625	626	627	628	629	630	631	632	633	634	635	636	637	638
639	640	641	642	643	644	645	646	647	648	649	650	651	652	653
654	655	656	657	658	659	660	661	662	663	664	665	666	667	668
669	670	671	672	673	674	675	676	677	678	679	680	681	682	683
684	685	686	687	688	689	690	691	692	693	694	695	696	697	698
699	700	701	702	703	704	705	706	707	708	709	710	711	712	713
714	715	716	717	718	719	720	721	722	723	724	725	726	727	728
729	730	731	732	733	734	735	736	737	738	739	740	741	742	743
744	745	746	747	748	749	750	751	752	753	754	755	756	757	758
759	760	761	762	763	764	765	766	767	768	769	770	771	772	773
774	775	776	777	778	779	780	781	782	783	784	785	786	787	788
789	790	791	792	793	794	795	796	797	798	799	800	801	802	803
804	805	806	807	808										

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Index

Key

ex to Products Advertised—*Continued*

WHAT'S NEW

• A new folder, **Form No. M-955, on Dor-O-Matic Manual Door Controls** is offered by the Dor-O-Matic Division of Republic Industries, Inc., 4446 N. Knox Ave., Chicago 30. A complete description of the 25 models of the new concealed-in-the-floor door control units that control as they open and as they close is given in the folder together with data on application of the various models.

For more details circle #586 on mailing card.

• Descriptive information on the redesigned Ionograph for paper strip electrophoresis is contained in **Bulletin 690A** published by Precision Scientific Co., 3737 W. Cortland St., Chicago 47. The new bulletin also discusses ionographic studies which may be performed with the apparatus.

For more details circle #587 on mailing card.

• The role of recreation as a therapeutic adjunct to other hospital services is the subject of a new 16 mm film entitled **"Rx Recreation."** The 28 minute sound film in full color shows dramatically how recreation helps to meet the physical and emotional needs of the ill, handicapped and convalescent patient. The film draws on actual experience in hospitals in New York City and is available for rental or purchase through the National Recreation Association, 8 W. Eighth St., New York 11.

For more details circle #588 on mailing card.

• **"Blueprint for Tomorrow"** is the title of an attractively laid out and printed booklet released by United States Gypsum Co., 300 W. Adams St., Chicago 4. The story of the company's growth to meet the nation's need is told in words and pictures, with data on preparations to meet the challenge of tomorrow.

For more details circle #589 on mailing card.

• How the **Lowry Patient Elevator** moves patients in and out of bed, from bed to surgery or ambulance and in other areas is discussed in a folder released by Lowry Mfg. Co., 7149 Wilshire Blvd., Des Moines, Iowa. Patients are moved comfortably, without lifting, and with complete ease by nurse or other attendant using the Patient Elevator. Descriptive information on its simple controls and operation, as well as its many uses, is given in the folder which employs photographs to demonstrate the adaptability of the device.

For more details circle #590 on mailing card.

• Automatic emergency lighting equipment is described in **Bulletin E.L. 16** issued by Surrette Storage Battery Co., Inc., Salem, Mass. The Surrette Model E Automatic Emergency Lighting Unit and how it can be used in case of power failure or other emergency is discussed. Details are included on the rechargeable battery unit and its operation.

For more details circle #591 on mailing card.

• Several new types and sizes of surgical sutures are added in the new **Hospital Product Guide** released by J. A. Deknatel & Son, Inc., 96-20 222nd St., Queens Village 29, N. Y. The 16 page catalog gives purchasing data on surgical gut, cotton, silk, stainless steel, Dermal and nylon.

For more details circle #592 on mailing card.

• **"Floor Cleaning Equipment by Geerpress"** is the subject of a 20 page catalog (No. 955) released by Geerpres Wringer, Inc., Muskegon, Mich. Included in the catalog is descriptive information on mop wringers, Jet Streem mop washer, handles for twin-chassis mopping outfits, buckets, mop sticks and the almost fifty different items of cleaning equipment manufactured by the company.

For more details circle #593 on mailing card.

Suppliers' News

Owens-Illinois Glass Co., Toledo 1, Ohio, manufacturer of glass products, announces the opening of the **Owens-Illinois Technical Center in Toledo, Ohio.** The attractive modern building is equipped to take a project from the fundamental theory through final pilot plant testing under commercial conditions. Five hundred scientists and engineers work in the new center, constantly seeking new and improved glass products and better ways of making them.

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Hall China bean pots and marmites are available in sizes ranging from individual to banquet service; custards and ramekins in all popular sizes.

Hall China marmites, bean pots, and custards are the most economical dishes to use . . . sturdy, crazeproof, stainproof, always new and fresh in appearance—and the easiest of all ware to clean. Hall China is heavy, fireproof china made by an exclusive process which inseparably fuses body, glaze, and color.

Write for Bulletin SM-1 which lists and illustrates Hall casseroles, baking dishes, coffee and teapots, creamers, jugs, ash trays, salads, and many other items available in 26 beautiful underglaze colors.

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO

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Secret Process
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The skill of master craftsmen helps make Hall China uniformly superior in quality.

THE VAST MAJORITY OF THE NATION'S FINE BUILDINGS ARE SLOAN EQUIPPED

CROW ISLAND ELEMENTARY SCHOOL *in Winnetka, Illinois, was once described as looking—from above—"like a giant game of checkers spread out on a lush green setting."*

Photo • GORDON COSTER

Photos • KRANZTEN STUDIOS, Inc.

for the new Crow Island School Addition:

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architects and engineers

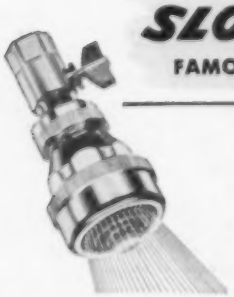
VICTOR J. KILLIAN
plumbing contractor

INLAND SUPPLY CO.
plumbing wholesaler

AMERICAN RADIATOR & STANDARD SANITARY CORP.
plumbing fixtures

"AN ASTONISHING BUILDING"

• Back in 1940, the newly completed CROW ISLAND SCHOOL, Winnetka, Illinois, was acclaimed "an astonishing building. For the first time, modern elementary education was provided with housing to fit it." Famed architects, working with a far-sighted and highly creative school administration, applied originality in planning "a functional atmosphere for living and learning." Today—15 years later—this pioneer successfully maintains its firmly established position as "the most influential school of modern times." It has been the designing inspiration for hundreds of schools which have since been built. Last Spring, after completion of a new wing, this school was visited by a large group of architects whose interests are centered in the need for more and better school buildings. During Crow Island planning and construction in 1954, as in 1940, highest quality standards prevailed. Throughout all units of the new wing, as in the main building, are service products of known superiority. In both, as in many thousands of other fine buildings, are famous SLOAN *Flush* VALVES.



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Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

Write for completely descriptive folder